Medicare Physician Guide

A Resource for Residents, Practicing Physicians, and Other Health Care Professionals

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MEDICARE PHYSICIAN GUIDE:
A Resource for Residents, Practicing Physicians, and Other Health Care Professionals

Eighth Edition – April 2006

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Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 enacted numerous contracting reforms. A key aspect of these reforms is that Medicare will begin integrating Fiscal Intermediaries (FI) and Carriers into a new single authority, called a Medicare Administrative Contractor (MAC). As of October 1, 2005, new Medicare Contractors are called MACs. Also, from October 2004 through October 2011, all existing FI and Carrier contracts

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will be transitioned into MAC contracts, using competitive procedures. Providers may access the most current MCR information to determine the impact of these changes at *www.cms.hhs.gov/MedicareContractingReform* on the CMS website.

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TABLE OF CONTENTS

Chapter 1 **Introduction to the Medicare Program**.....1

- The Medicare Program
- Medicare Eligibility
- Identifying Medicare Beneficiaries
- Organizations That Impact the Medicare Program
- Recent Laws That Impact the Medicare Program

Chapter 2 **Becoming a Medicare Provider or Supplier**.....15

- Medicare Providers and Suppliers
- Enrolling in the Medicare Program
- Protecting Your Practice
- Promoting Cultural Competency and Enhancing Quality in Your Practice

Chapter 3 **Medicare Reimbursement**.....33

- Medicare Claims
- Deductibles, Coinsurance, and Copayments
- Coordination of Benefits
- Incentive and Bonus Payments
- Medicare Notices
- Other Health Insurance Plans
- Documentation
- National Correct Coding Initiative
- Comprehensive Error Rate Testing

Chapter 4 **Medicare Payment Policies**.....53

- Services That Medicare DOES Pay For
- Commonly Furnished Services
- Services That Medicare Does NOT Pay For

Chapter 5 **Evaluation and Management Documentation**.....85

- Guidelines for Residents and Teaching Physicians
- Evaluation and Management Background
- Reference I - *1995 Documentation Guidelines for Evaluation and Management Services*
- Reference II - *1997 Documentation Guidelines for Evaluation and Management Services*

Chapter 6 **Protecting the Medicare Trust Fund**.....159

- Data Analysis
- Medical Review
- Coverage Determinations
- Fraud and Abuse
- Significant Medicare Fraud and Abuse Provisions
- Potential Legal Actions
- Incentive Reward Program
- Whistle Blower Provision
- How to Report Suspected Fraud or Abuse

Chapter 7 **Inquiries, Overpayments, and Appeals**.....173

- Inquiries
- Overpayments
- Fee-for-Service Appeals

Reference Section.....185

- Reference A – Glossary
- Reference B – Acronyms
- Reference C – Helpful Websites
- Reference D – Reference Materials

CHAPTER 1

INTRODUCTION TO THE MEDICARE PROGRAM

The Centers for Medicare & Medicaid Services (CMS) is an Agency within the U.S. Department of Health and Human Services (HHS) that administers and oversees the Medicare, Medicaid, and State Children's Health Insurance Programs and awards contracts to organizations called Contractors who perform claims processing and related administrative functions. Beginning in 2006, all Original Medicare Plan claims processing Contractors (Fiscal Intermediaries [FI], Carriers, and Durable Medical Equipment Carriers) will be transitioned into Medicare Administrative Contractors (MAC). See the Recent Laws That Impact the Medicare Program Section below for additional information about MACs. CMS also regulates laboratory testing and surveys and certifies nursing homes, health care agencies, intermediate care facilities for the mentally retarded, and hospitals. CMS' Central Office is located in Baltimore, Maryland, and provides operational direction and policy guidance for the nationwide administration of the above programs. CMS Regional Offices are located in 10 major cities throughout the U.S. and support the health care provider community by:

- Conducting outreach activities;
- Establishing relationships with local and regional provider associations; and
- Helping providers and suppliers resolve disputes they may have with Contractors.

The Medicare Program

The Medicare Program was established by Title XVIII of the Social Security Act on July 1, 1966. It provides medical coverage to 95 percent of the nation's aged population including individuals age 65 or older, certain disabled individuals, and individuals with End-Stage Renal Disease (ESRD).

Medicare consists of the following four parts:

- Part A, hospital insurance;
- Part B, medical insurance;
- Part C, Medicare Advantage (MA); and
- Part D, prescription drug plan.

Part A

Medicare Part A is hospital insurance. Some of the services that Part A helps pay for include:

- Inpatient hospital care;
- Inpatient care in a Skilled Nursing Facility (SNF) following a covered hospital stay;
- Some home health care; and
- Hospice care.

Part A is financed by:

- Payroll taxes paid by employers and employees through the Federal Insurance Contributions Act;
- Self-employed individual contributions through the Self-Employment Contributions Act; and
- Contributions from railroad workers and their employers or representatives through the Railroad Retirement Act.

Part B

Medicare Part B is medical insurance. Some of the services that Part B helps pay for include:

- Medically necessary services furnished by physicians in a variety of medical settings including but not limited to:
    - The physician's office
    - An inpatient or outpatient hospital setting and
    - Ambulatory Surgical Centers
- Home health care
- Ambulance services
- Clinical laboratory and diagnostic services
- Surgical supplies
- Durable medical equipment and supplies
- Services furnished by practitioners with limited licensing such as:
    - Advanced registered nurse practitioners
    - Independently practicing physical therapists
    - Independently practicing occupational therapists
    - Certified registered nurse anesthetists
    - Licensed clinical social workers
    - Audiologists
    - Nurse midwives
    - Clinical psychologists
    - Physician assistants

Medicare Part B is financed by:

- Premium payments by enrollees;
- Contributions from general Federal government revenues; and
- Interest earned on the Part B trust fund.

Part C or Medicare Advantage

Part C or MA, previously known as Medicare + Choice, is a program through which organizations that contract with CMS provide or arrange for the provision of health care services to Medicare beneficiaries who:

- Are entitled to Part A and enrolled in Part B
- Permanently reside in the service area of the MA Plan; and
- Elect to enroll in a MA Plan.

Individuals with ESRD are generally excluded from enrolling in MA Plans.

CMS generally pays the MA organization a fixed amount, or capitation rate, and the MA organization then reimburses providers and suppliers who participate in the MA Plan(s) offered by the MA organization for services furnished within the terms of the agreement/plan.

When the beneficiary is a member of a MA Plan, the plan is responsible for paying claims when a provider or supplier:

- Is affiliated with the MA Plan; or
- Furnishes emergency services, urgently needed services, or other covered services that are not reasonably available through a provider or supplier affiliated with the MA Plan.

Beginning in 2006, the MA Program will include a new option, regional Preferred Provider Organization (PPO) Plans, which are similar to local PPO plans but must have a service area that encompasses one or more of the 26 MA regions established by the Secretary of HHS. Beneficiaries will be able to choose options such as Private Fee-For-Service Plans (PFFS), Health Maintenance Organizations, and local or regional PPO Plans. In addition, these changes provide new opportunities for rural providers and suppliers who may choose to:

- Enter into contracts with MA organizations to furnish health care services to MA enrollees. In general, the provisions of these contracts, including payment rates, are negotiated between MA organizations and providers and suppliers.
- Elect to furnish services to MA enrollees on a non-contract basis. In general, when providers and suppliers furnish services to MA enrollees on a non-contract basis, the MA organization pays them what they would have been paid had they furnished services to beneficiaries in the Original Medicare Plan. Providers and suppliers who elect to furnish services to beneficiaries enrolled in PFFS Plans must follow the PFFS Plan terms and conditions of payment.

Medicare beneficiaries may choose to join or leave a MA Plan during one of the following election periods:

- Initial Coverage Election Period (ICEP), which begins three months immediately before the individual's entitlement to both Medicare Part A and Part B and ends on the later of either the last day of the month preceding entitlement to both Part A and Part B or the last day of the individual's Part B IEP. If the beneficiary chooses to join a Medicare health plan during this period, the Plan must accept him or her unless the Plan has reached its member limit.
- Annual Coordinated Election Period (AEP), which occurs each year between November 15 and December 31. The Plan must accept all enrollments during this time, unless it has reached its member limits. A special AEP for the Medicare prescription drug program will occur from November 15, 2005 through May 15, 2006.
- SEP, during which time the beneficiary may change MA Plans or return to the Original Medicare Plan. One of the following situations must have occurred for the beneficiary to join or leave a plan during this period:
    - He or she permanently moves outside the service area
    - He or she has both Medicare and Medicaid
    - He or she resides in, moves into, or moves out of an institution or
    - Other exceptions as determined by CMS
- Open Enrollment Period (OEP), during which time the beneficiary may leave or join another MA Plan if it is open and accepting new members. Elections made during this period must be made to the same type of plan (regarding Medicare prescription drug coverage) in which the individual is already enrolled. In 2006, the OEP occurs from January through June. In 2007 and beyond, the OEP will occur from January through March. If a plan chooses to be open, it must allow all eligible beneficiaries to join or enroll.

Part D

Section 101 of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) created Medicare Part D, which provides prescription drug coverage to all beneficiaries electing to enroll in a prescription drug plan beginning on January 1, 2006. Beneficiaries who have Medicare Part A and/or Medicare Part B can enroll between November 15, 2005 and May 15, 2006.

Defined standard coverage in 2006 includes:

- An estimated average $32.20 monthly premium (this is an estimated amount; the premium depends on plan bids and which prescription drug plan or MA Plan the beneficiary selects).
- $250.00 yearly deductible.

- On average 25 percent coinsurance up to an initial coverage limit of $2,250.
- After the initial coverage limit of $2,250 but before the catastrophic limit of $3,600 of true out-of-pocket (TrOOP) spending has been reached, the beneficiary pays 100 percent of prescription drug costs.
- Catastrophic coverage once a beneficiary has spent $3,600 of his or her own money out-of-pocket for the year. This coverage consists of the greater of:
    - A $2.00 copayment for generics and preferred multiple source drugs or a $5.00 copayment for all other drugs or
    - 5 percent of the negotiated price

Beneficiaries will receive the full low-income subsidy, also known as extra help, when:

- Their income is below 135 percent of the Federal poverty level (FPL);
- For 2006, their resources do not exceed three times the amount allowed for Supplemental Security Income (SSI);
- They apply for the subsidy; and
- They are found eligible for the subsidy.

Beneficiaries who receive a full Medicaid benefic package, help from their State Medicaid Program to pay their Medicare premiums, or a cash benefit from SSI will also receive the full low-income subsidy which includes:

- A reduction in the premium, up to the low-income premium subsidy amount for the region, but never to exceed the plan's premium for basic prescription drug coverage.
- No yearly deductible.
- One of the following three copayment structures until a catastrophic limit is reached:
    - A $2.00 copayment for generics and preferred multiple source drugs or a $5.00 copayment for all other drugs
    - A $1.00 copayment for generics and preferred multiple source drugs and a $3.00 copayment for all other drugs for beneficiaries who are eligible for full benefits under Medicare and Medicaid (full-benefit dual eligible beneficiaries) with incomes under 100 percent of the FPL or
    - No copayment for residents of SNFs and other long-term care facilities who are full-benefit dual eligibles
- Once the catastrophic limit of $3,600 out-of-pocket is reached, there is no copayment for all prescriptions. The government subsidy for cost sharing counts toward the out-of-pocket threshold for catastrophic coverage.

There is also a partial subsidy for beneficiaries with limited assets and incomes between 135 and 150 percent of the FPL. This subsidy also applies to beneficiaries with incomes below 135 percent of the FPL if their assets are such that they cannot meet the asset test for incomes below 135 percent of the FPL, but can meet the higher asset test used for those with incomes below 150 percent of the FPL. This coverage includes:

- A premium subsidy based on a sliding scale from no premium subsidy up to the low-income premium subsidy amount for the region, but never to exceed the plan's premium for basic prescription drug coverage.
- $50.00 yearly deductible.
- No more than 15 percent coinsurance up to the catastrophic limit.
- Copayments not to exceed $2.00 for generic or preferred multiple source drugs or $5.00 for all other drugs once the catastrophic limit is reached. The government subsidy for cost sharing counts toward the catastrophic limit.

A new exception to the Anti-Kickback Statute has been added under which pharmacies are permitted to waive or reduce cost-sharing amounts provided they do so in an unadvertised, nonroutine manner after determining that the beneficiary in question is financially needy or after failing to collect the cost-sharing amount despite reasonable efforts. In addition, pharmacies may waive or reduce a beneficiary's Part D cost-sharing without regard to these standards for Part D enrollees eligible for the low-income subsidy provided they do not advertise that the waivers or cost-sharing reductions are available. To the extent that the party paying for cost-sharing on behalf of a Part D enrollee is a group health plan, insurance, government-funded health program, or party to a third party payment arrangement with an obligation to pay for covered Part D drugs, that party's payment will not count toward TrOOP expenditures. Thus, payments made for beneficiary cost-sharing by any entity, including a 340B pharmacy, that has an obligation to pay for covered Part D drugs on behalf of Part D enrollees or voluntarily elects to use public funds for that purpose will not count toward that beneficiary's TrOOP expenditures. By law there are several broad exceptions to the TrOOP requirements, including:

- Assistance provided by family members;
- Help from state pharmaceutical assistance programs;
- Assistance from charities unaffiliated with employers or unions, including patient assistance programs; and
- Low-income cost sharing subsidies.

Medicare beneficiaries may only choose to join or leave a Medicare prescription drug plan during the following enrollment periods:

- IEP Part D: At the beginning of the Medicare prescription drug coverage program, all current Part D eligible individuals have an IEP that begins on November 15, 2005 and ends on May 15, 2006. Individuals who become newly eligible for Medicare will have an IEP for Part D that is the same period as the ICEP for Medicare Part B.
- AEP, which occurs each year between November 15 and December 31. The Medicare prescription drug plan must accept all enrollments during this time. A special AEP for the Medicare prescription drug program will occur from November 15, 2005 through May 15, 2006.
- SEP, during which time the beneficiary may leave or join another Medicare prescription drug plan. One of the following situations must have occurred for the beneficiary to join or leave a plan during this period:
    - He or she permanently moves outside the service area
    - He or she has both Medicare and Medicaid
    - He or she moves into, resides in, or moves out of an institution or
    - Other exceptions as determined by CMS

Medicare Eligibility

There are three groups of Medicare insured beneficiaries:

1) Aged Insured

Aged insured beneficiaries are at least 65 years old and eligible for Social Security, Railroad Retirement, or equivalent Federal benefits. For Medicare purposes, beneficiaries attain age 65 the day before their actual 65th birthday. Medicare Part A is effective on the first day of the month upon attainment of age 65. For an individual whose 65th birthday is on December 1, Part A is effective on November 1 since for Medicare purposes, he or she attained age 65 on November 30. To be eligible for premium-free Part A coverage, an individual must be insured based on his or her own earnings or the earnings of a spouse, parent, or child. Individuals age 65 or older who do not meet insured status requirements for premium-free Part A may enroll in Part A on a premium paying basis if they are entitled to or enrolled in Medicare Part B. **Premium** Part A coverage may be terminated if one of the following occur:

- A voluntary request;
- Nonpayment of premium;
- End of entitlement to Medicare Part B; or
- Death.

Part B coverage is voluntary and becomes effective when an individual enrolls and begins to pay the monthly premium. The period that an individual may enroll in Part B begins 3 months before he or she attains age 65 and lasts for 7 months. If an individual enrolls during the last four months of his or her Initial Enrollment Period (IEP), the Part B effective date will be delayed. If an individual chooses not to enroll in Medicare Part B during the IEP, he or she may enroll during one of the following periods:

- General Enrollment Period, which takes place from January 1 through March 31 of each year. Coverage will be effective on July 1.
- Special Enrollment Period (SEP), which is for those who did not enroll because of current employment or a spouse's current employment and are covered by a Group Health Coverage (GHP). Enrollment may occur:
    - Anytime they are still covered by the GHP through their current employment
    - During the eight months following the month the GHP coverage ends or
    - When employment ends (whichever is first)

All individuals who are entitled to premium-free Part A are eligible to enroll in Part B. Individuals who are not eligible for premium-free Part A can enroll in Part B if they are:

- Age 65;
- A resident of the U.S.; and
- A U.S. citizen or an alien who has been lawfully admitted for permanent residence and has resided continuously in the U.S. during the five years preceding the month in which he or she applies for enrollment.

Medicare Part B may be terminated when one of the following occurs:

- A voluntary request;
- Nonpayment of premium; or
- Death.

2) Disabled Insured

Disabled insured beneficiaries are automatically entitled to Medicare Part A after receiving Social Security disability cash benefits for 24 months and are enrolled in Medicare Part B unless they refuse Part B coverage. This coverage is also available to certain disabled widows, widowers, and disabled children of deceased, disabled, or retired workers. Beginning July 1, 2001, individuals

whose disability is Amyotrophic Lateral Sclerosis are entitled to Medicare the first month they are entitled to Social Security disability cash benefits. Part A terminates:

- The month following the month the notice of disability termination is mailed;
- The attainment of age 65 (entitlement continues as an aged insured); or
- The date of death.

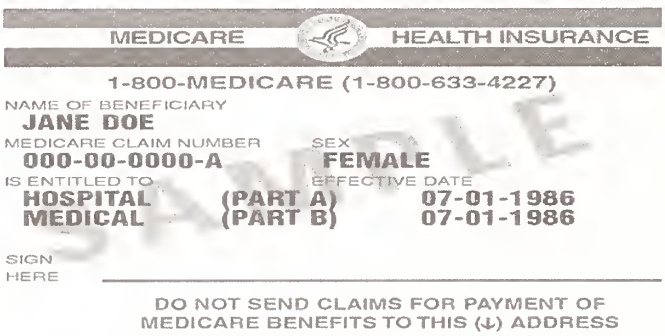
3) End-Stage Renal Disease Insured

ESRD insured beneficiaries are individuals of any age who in order to maintain life receive regular dialysis treatments or a kidney transplant, have filed an application, and meet one of the following conditions:

- Certain work requirements for Social Security insured status (or would meet those requirements if certain Federal government employment qualified as employment for Social Security benefits) or entitled to monthly Social Security benefits;
- Eligible under Railroad Retirement Programs or entitled to an annuity under the Railroad Retirement Act; or
- Is the spouse or dependent child of an insured individual.

Identifying Medicare Beneficiaries

When an individual becomes entitled to Medicare, CMS or the Railroad Retirement Board (RRB) issues a health insurance card like the one depicted below.



Office staff should regularly request the patient's health insurance card and picture identification to verify that services are furnished only to individuals eligible to receive Medicare benefits. Copies of the health insurance card and picture identification should be made for the patient's medical file.

The following information can be found on the health insurance card:

- Name;
- Sex;
- Medicare Health Insurance Claim (HIC) number;
- Effective date of entitlement to Part A; and/or
- Effective date of entitlement to Part B.

The HIC number on the health insurance card issued by CMS has an alpha or alphanumeric suffix and the Social Security Number (SSN), which is usually either the SSN of the insured or the spouse of the insured (depending on whose earnings eligibility is based). The HIC number on the health insurance card issued by the RRB has an alpha prefix and one or more characters and the insured's SSN, a six-digit number, or a nine-digit number.

Organizations That Impact the Medicare Program

The following organizations impact the Medicare Program.

Federal Government

- U.S. House of Representatives
  - Ways and Means Committee
  - Appropriations Committee and
  - Energy and Commerce Committee

- U.S. Senate
  - Appropriations Committee
  - Finance Committee and
  - Energy and Commerce Committee

The *Commerce Clearing House Guide to Medicare and Medicaid* describes proposed legislative changes to the Medicare Program and may be purchased from:

Commerce Clearing House, Inc.
4025 West Peterson Avenue
Chicago, IL 60646-6085
www.cch.com
Telephone: (800) 835-5224

- The Social Security Administration determines eligibility for Medicare benefits and enrolls individuals in Part A and/or B and the Federal Black Lung Benefit Program. It completes the following activities:
  - Replaces lost or stolen Medicare cards
  - Makes address changes
  - Collects premiums from beneficiaries and
  - Educates beneficiaries about coverage and insurance choices

- The Office of Inspector General (OIG) protects the integrity of HHS programs and the health and welfare of beneficiaries of those programs through a nationwide network of audits, investigations, inspections, and other mission-related functions.

State Government

- State agencies survey all Medicare Part A and certain Part B providers and suppliers and make recommendations about their suitability for participation in the Medicare Program. State agencies also assist providers and suppliers in sustaining quality standards.

Other Organizations

- Quality Improvement Organizations (QIO) (formerly known as Peer Review Organizations) are organizations that CMS contracts with to:
    - Conduct quality improvement projects
    - Promote the use of publicly-reported performance data
    - Conduct outreach activities for beneficiaries and health care providers and suppliers
    - Respond to written complaints from Medicare beneficiaries or their representatives about the quality of services for which Medicare payment may be made
    - Monitor payment errors to reduce fraud and abuse and
    - Ensure that patient rights are protected

QIOs are required to develop an ongoing process of learning about and contacting organizations in their state that have an interest in health care delivery and policy including organizations that represent disadvantaged communities, rural, and non-English speaking populations. These organizations include major religious, community service, civic, union, consumer, public service, and other organizations. Additional information about QIOs and a link to the directory of QIOs can be found at *www.cms.hhs.gov/QualityImprovementOrgs/01_Overview.asp#TopOfPage* on the CMS website.

State Health Insurance Assistance Program

The State Health Insurance Assistance Program (SHIP) is a national program that offers free one-on-one counseling and assistance to people with Medicare and their families through interactive sessions, public education presentations and programs, and media activities. There are SHIPs in all 50 states, Washington, D.C., Puerto Rico, and the Virgin Islands. SHIP-trained counselors provide a wide range of information about long-term care insurance; Medigap; fraud and abuse; and the Medicare, Medicaid, and public benefit programs for those with limited income and assets. To find additional information about SHIPs and a link to State Health Insurance offices, visit *www.cms.hhs.gov/Partnerships/10_SHIPS.asp* on the CMS website.

Recent Laws That Impact the Medicare Program

Medicare Prescription Drug, Improvement, and Modernization Act of 2003
The MMA provides the most dramatic and innovative changes to Medicare since it began in 1965. The chart below depicts Titles I – XII of the MMA.

TITLE	PROVISION
Title I	Medicare Prescription Drug Benefit (see the Part D Section above for information about prescription drug coverage)
Title II	Medicare Advantage
Title III	Combating Waste, Fraud, and Abuse
Title IV	Rural Provisions
Title V	Provisions Relating to Part A
Title VI	Provisions Relating to Part B
Title VII	Provisions Relating to Parts A and B
Title VIII	Cost Containment
Title IX	Administrative Improvements, Regulatory Reduction, and Contracting Reform
Title X	Medicaid and Miscellaneous Provisions
Title XI	Access to Affordable Pharmaceuticals
Title XII	Tax Incentives for Health and Retirement

Medicare Contracting Reform
Section 911 of the MMA enacted numerous contracting reforms. A key aspect of these reforms is that Medicare will begin integrating FIs and Carriers into new single authorities called MACs. As of October 1, 2005, new Medicare Contractors are called MACs. Also, from October 2004 through October 2011, all existing FI and Carrier contracts will be transitioned into MAC contracts using competitive

procedures. In 2006, MACs will replace all Durable Medical Equipment Regional Carriers and will begin operations to replace Fiscal Intermediaries and Carriers in Arizona, Utah, Montana, Wyoming, North Dakota, and South Dakota. Providers may access the most current Medicare Contracting Reform information to determine the impact of these changes at *www.cms.hhs.gov/MedicareContractingReform* on the CMS website.

Physical Therapy, Occupational Therapy, and Speech-Language Pathology Services

The MMA extended the moratorium on the financial limitation of outpatient physical therapy, occupational therapy, and speech-language pathology services until December 31, 2005. Unless there is a change in the statute, limitations will apply on January 1, 2006. To find updated information on therapy caps, visit *www.cms.hhs.gov/TherapyServices* on the CMS website.

To find additional information about the MMA, visit *www.cms.hhs.gov/MMAUpdate* on the CMS website.

Health Insurance Portability and Accountability Act of 1996

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 was enacted on August 21, 1996 and established the following:

- National standards for electronic health care transactions and national identifiers for providers, health plans, and employers;
- Safeguards to protect the security and privacy of health data;
- The Health Care Fraud and Abuse Control Account, which helps finance expanded fraud and abuse control activities; and
- Health insurance coverage protection for workers and their families when they change or lose their jobs.

To find additional information about HIPAA, visit *www.cms.hhs.gov/HIPAAGenInfo* on the CMS website.

To find additional information about the Medicare Program, see the Medicare General Information, Eligibility, and Entitlement Manual (Pub. 100-1) at *www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage* on the CMS website. Beneficiaries can receive Medicare information 24 hours a day, 7 days a week by visiting *www.medicare.gov* on the Medicare website or by telephoning (800) 633-4227.

CHAPTER 2

BECOMING A MEDICARE PROVIDER OR SUPPLIER

This chapter discusses how to become a Medicare provider or supplier.

Medicare Providers and Suppliers

The Medicare Program recognizes a broad range of providers and suppliers who furnish the necessary services and supplies to meet the health care needs of beneficiaries.

Part A

Medicare makes payment under Part A for certain services furnished by the following types of entities:

- Critical Access Hospitals;
- Federally Qualified Health Centers;
- Histocompatibility Laboratories;
- Home Health Agencies (including sub-unit);
- Hospice;
- Hospitals (acute care inpatient services);
- Indian Health Services Facilities;
- Inpatient Rehabilitation Facilities;
- Long Term Care Hospitals;
- Multiple hospital components in a medical complex;
- Organ Procurement Organizations;
- Psychiatric units (of hospital);
- Religious Non-Medical Health Care Institutions (formerly Christian Science Sanatorium);
- Rural Health Clinics; and
- Skilled Nursing Facilities (SNF).

Part B

Medicare makes payment under Part B for certain services furnished by the following:

- Ambulance service suppliers;
- Ambulatory Surgical Centers (ASC);
- Clinical psychologists (CP);
- Community Mental Health Centers;
- Comprehensive Outpatient Rehabilitation Facilities;
- Durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers (including pharmacies);
- End-Stage Renal Disease Facilities;
- Home Health Agencies (outpatient Part B services);
- Hospitals (outpatient services);
- Independent diagnostic testing facilities;
- Nurse practitioners (NP);
- Occupational therapists in private practice
- Other nonphysician practitioners (NPP);
- Outpatient physical therapy (PT);
- Outpatient speech-language pathology suppliers;
- Physical therapists in private practice;
- Physicians; and
- SNFs (outpatient services).

Physicians

The Medicare Program defines physicians to include the following:

- Doctors of medicine and doctors of osteopathy;
- Doctors of dental surgery or dental medicine;
- Chiropractors;
- Doctors of podiatry or surgical chiropody; or
- Doctors of optometry.

In addition, the Medicare physician must be legally authorized to practice by a state in which he or she performs this function. The services performed by a physician within these definitions are subject to any limitations imposed by the state on the scope of practice. The issuance by a state for a license to practice medicine constitutes legal authorization. A temporary State license also constitutes legal authorization to practice medicine. If State law authorizes local political subdivisions to establish higher standards for medical practitioners than those set by the State licensing board, the local standards are used in determining whether the physician has legal authorization. If the State licensing law limits the scope of practice of a particular type of medical practitioner, only the services within these limitations are covered.

Interns and residents include physicians who:

- Participate in approved postgraduate medical training programs; or
- Are not in approved programs, but are authorized to practice only in a hospital setting (e.g., have temporary or restricted licenses or are graduates of foreign medical schools).

The status of senior residents who have staff or faculty appointments or are designated as fellows does not change for the purpose of Medicare coverage and payment.

Medical and surgical services furnished by interns and residents within the scope of their training program are covered as provider services. This includes services furnished in a setting that is not part of the provider where (among other things) the provider has agreed to incur all or substantially all the costs of training in the nonprovider facility. The Medicare Contractor must be notified when interns, residents, and providers enter into this type of agreement. When a licensed intern or resident physician performs the services but the provider incurs little or none of the training costs, the services are paid under the Medicare Physician Fee Schedule (MPFS). Medical and surgical services furnished by the intern or resident are considered to have been furnished in his or her capacity as a physician, not in his or her capacity as an intern or resident when:

- The services furnished are not related to the training program, the services are furnished outside the training program facility, and the following criteria are met:
    - The services are identifiable physician services that require performance by a physician in person and contribute to the diagnosis or treatment of the patient's condition and
    - The intern or resident is fully licensed to practice medicine, osteopathy, dentistry, or podiatry by the state in which the services are performed
- The services furnished are not related to the training program, the services are furnished in an outpatient department or emergency room of the training program hospital, and the following criteria are met:
    - The services are identifiable physician services that require performance by a physician in person and contribute to the diagnosis or treatment of the patient's condition
    - The intern or resident is fully licensed to practice medicine, osteopathy, dentistry, or podiatry by the state in which the services are performed and
    - The services can be separately identified from those services that are required as part of the training program

A teaching physician is a physician (other than an intern or resident) who involves residents in the care of his or her patients. Generally, the teaching physician must be present during all critical and key portions of the procedure and immediately available to furnish services during the entire service in order for the service to be payable under the MPFS.

Practitioners

The Medicare Program defines a practitioner as any of the following to the extent that an individual is legally authorized to practice by the state and otherwise meets Medicare requirements:

- Physician assistant (PA);
- NP;
- Clinical nurse specialist (CNS);
- Certified registered nurse anesthetist (CRNA);
- Certified nurse midwife (CNM);
- CP;
- Clinical social worker (CSW); or
- Registered dietician or nutrition professional.

Enrolling in the Medicare Program

To obtain reimbursement from Medicare, providers and suppliers must first enroll in the program by completing the appropriate Provider/Supplier Enrollment Application. In the enrollment process, the Centers for Medicare & Medicaid Services (CMS) collects information about the applying provider or supplier and secures documentation to ensure that the he or she is qualified and eligible to enroll in the Medicare Program. Depending upon provider or supplier type, one of the following forms is completed to enroll in the Medicare Program:

- Form CMS-855A: Institutional providers (see the Institutional Providers and Suppliers Section below for additional information);
- Form CMS-855B: Organizational suppliers including group practices (see the Physician-Directed Group/Clinic Practice Section below for additional information);
- Form CMS-855I: Individual physicians/practitioners who bill Medicare directly (see the Individual Physicians and Nonphysician Practitioners Section below for additional information);
- Form CMS-855R: Individual physicians/practitioners; allows payment to a group practice or other eligible party (see the Reassignment of Benefits Section below for additional information); and
- Form CMS-855S: DMEPOS suppliers.

The following forms are often required in addition to the CMS-855 form:

- Form CMS-588: Medicare authorization agreement for electronic funds transfers (for providers who choose to have payments sent directly to their financial institution);
- Form CMS-460: Agreement to become a Part B participating provider or supplier who will accept assignment of Medicare benefits for all covered services for all patients (see the Participating and Nonparticipating Providers and Suppliers Section below for additional information); and
- Electronic Data Interchange Agreement: Agreement to follow provisions related to electronically submitting claims to Medicare Contractors.

The above forms are available at *www.cms.hhs.gov/CMSForms/CMSForms/list.asp#TopOfPage* on the CMS website.

Additional forms, which may vary from state to state, may also be required in order to enroll in the Medicare Program. These forms include the following:

- State medical license;
- Occupational or business license; and
- Certificate of Use.

After all forms have been completed and signed, the packet is then mailed to the appropriate Medicare Contractor for processing. Information about where to send the packet can be found at *www.cms.hhs.gov/MedicareProviderSupEnroll/PSEC/list.asp#TopOfPage* on the CMS website. For most applicants, the enrollment process takes 60 days. CMS requires its Contractors to process 90 percent of enrollment applications within 60 calendar days of receipt or earlier and 99 percent of applications within 120 calendar days of receipt.

When an enrollment change occurs, the change must be reported to the Medicare Contractor within 90 days by completing the same form that is used for initial enrollment in the Medicare Program.

Upon acceptance into the Medicare Program, providers and suppliers are assigned certain identification numbers:

- National Provider Identifier

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 mandated that the Secretary of the Department of Health and Human Services (HHS) adopt a standard unique identifier for health care providers, suppliers, health plans, and organizations called the National Provider Identifier (NPI). All HIPAA-covered entities (including Medicare, Medicaid, private health plans, and all health care clearinghouses) must use only an NPI to identify HIPAA-covered health providers in standard transactions by May 23, 2007. Small health plans (less than 5 million dollars in annual revenues) must use only an NPI by May 23, 2008. These transactions include claims, eligibility inquiries and responses, referrals, and Remittance Advices. The NPI will replace the health care provider identifiers now being used in standard transactions including Medicare legacy identifiers (PIN, UPIN, Online Survey Certification and Reporting [OSCAR] numbers, and National Security Clearinghouse numbers). Obtaining an NPI does not eliminate Medicare Program enrollment requirements for health care providers and suppliers who wish to serve beneficiaries. The advantages of using an NPI include the following:

- Simpler electronic transactions of HIPAA standard transactions;
- Standard unique health identifiers for health care providers, health plans, and employers; and
- More efficient coordination of benefits transactions.

Providers and suppliers can apply for an NPI using one of the following methods:

- Visit *https://nppes.cms.hhs.gov* on the CMS website and complete the web-based application;
- Call (800) 465-3203 to request a paper application; or
- Submit an application to the National Plan and Provider Enumeration System via Electronic File Interchange.

The NPI Web Page for all health care providers and suppliers is located at *www.cms.hhs.gov/NationalProvIdentStand* on the CMS website. This page also contains a section a section for Medicare fee-for-service providers.

- Provider Identification Number (PIN) or individual billing number, which
  - Identifies who furnished the service to the beneficiary on the Medicare claim form
  - Allows providers and beneficiaries to receive payment for claims filed to the Medicare Contractor
  - Is required on all claims submitted to the Contractor; an "unprocessable" claim denial will result if the PIN is not included in the appropriate claim block or claim field and
  - Is issued by the Contractor

- Unique Physician/Practitioner Identification Number (UPIN) or individual identification number, which is:
  - A national number used to identify physicians/practitioners who order or refer services
  - A permanent number that may be used in any state where physicians/practitioners practice
  - Received by all physicians/practitioners enrolled in the Medicare Program who order or refer beneficiary services even though they might never bill Medicare directly
  - Received by individual physicians/practitioners (one number is assigned regardless of the number of practice settings) and
  - Assigned by CMS

The following services require a UPIN on the claim form:

- Consultation services;
- Routine foot care;
- DME and other medical supplies;
- Orthotic/prosthetic devices, including optical supplies;
- Most diagnostic services, including laboratory and radiology services;
- Services by independently-practicing PTs or OTs; and
- Any other service that is ordered or referred.

Institutional providers are assigned the following identifying number by the Medicare Contractor:

- OSCAR, which is
  - A Medicare billing number and unique identifier and
  - Issued by the CMS Regional Office

Institutional Providers and Suppliers

Institutional providers and suppliers must simultaneously contact their local State Agency (SA), which determines whether Medicare participation requirements and State requirements are met and evaluates the provider or supplier's performance and effectiveness in furnishing a safe and acceptable quality of care. To find contact information for SAs, visit *www.cms.hhs.gov/apps/contacts/* on the CMS website.

Individual Physicians and Nonphysician Practitioners

Individual physicians and NPPs bill the Medicare Contractor directly for their services and are issued an individual PIN. The address tied to the PIN is usually the physician or NPP's billing or mailing address, which may differ from the address where medical services are furnished.

Physician-Directed Group/Clinic Practice

A physician-directed group/clinic practice may be a partnership, association, or corporation composed of physicians or NPPs. Physicians and NPPs who wish to file claims as part of a group/clinic unit must request a group/clinic PIN number for billing purposes. The address tied to the PIN is usually the group/clinic's billing or mailing address, which may differ from the address where medical services are furnished.

Reassignment of Benefits

Ordinarily, Medicare pays the provider who furnishes the service. In limited situations, Medicare may allow physicians and practitioners who furnish services to reassign payment to another person or entity. This person or entity then bills Medicare on behalf of the physician or practitioner and receives payment for the services furnished. To reassign payment, each physician and practitioner within a group/clinic must complete Form CMS-855R, which states that he or she agrees to turn all monies over to the group/clinic. After the reassignment agreement has been signed, the Medicare Contractor will tie the individual provider's PIN to the group/clinic PIN. The group/clinic PIN is then used when claims are submitted for services performed as part of the group. Form CMS-855R must be competed and returned to the Medicare Contractor within 90 days of the effective date of the change in order to:

- Add a new reassignment;
- Terminate a current reassignment;
- Add a new practice location(s) for a current reassignment;
- Delete a practice location(s) from a current reassignment; or
- Change income reporting status.

Participating and Nonparticipating Providers and Suppliers

The chart below explains the two types of providers and suppliers in Part B of the Medicare Program.

Participating and Nonparticipating Medicare Part B Providers and Suppliers

Part B Participating Providers and Suppliers	Part B Nonparticipating Providers and Suppliers
Accept assignment of Medicare benefits for all covered services for all patients	May accept assignment of Medicare claims on a claim-by-claim basis (see below for the provider specialties and services that must always accept assignment)
Receive higher Medicare Physician Fee Schedule allowances than nonparticipating providers and suppliers	Receive lower Medicare Physician Fee Schedule allowances than participating providers and suppliers for assigned or nonassigned claims
Limiting charge provisions are not applicable (Medicare payment is accepted in full)	Are held to a limiting charge when submitting nonassigned claims (with the exception of pharmaceuticals, equipment, and supplies); may collect up the limiting charge at the time services are furnished
Included in the Medicare Participating Physician and Supplier Directory	Not included in the Medicare Participating Physician and Supplier Directory

By completing and signing Form CMS-460, the provider or supplier has formally notified CMS that he or she wishes to participate in the Medicare Program and will accept assignment of benefits for all covered services for all Medicare patients. Assignment means that the provider or supplier will be paid the Medicare allowed amount as payment in full for his or her services. The following services are always subject to assignment:

- Clinical diagnostic laboratory services and physician laboratory services;
- Physician services to individuals dually entitled to Medicare and Medicaid;
- Services of PAs, NPs, CNSs, CNMs, CRNAs, CPs, CSWs, and medical nutrition therapists;
- ASC services;
- Home dialysis supplies and equipment paid under Method II;
- Drugs; and
- Ambulance services.

Participation is valid for a yearlong period from January 1 through December 31. Active participants receive a participation package during the Medicare Contractor Open Enrollment Period, which is usually in November, when they can change their participation status for the following year. Providers and suppliers who wish to continue participating in the Medicare Program do not need to sign an agreement each year. The current agreement will remain in effect through December 31 of the calendar year in which the Medicare Contractor is notified about a change in status. Once Form CMS-460 is signed, CMS rarely honors a provider or supplier's decision to change participation status during the year.

Medicare allowed amounts can be found in the MPFS, which establishes payment policies and rates for over 10,000 procedures performed by providers, suppliers, and certain NPPs (e.g., NPs, PAs, and PTs). The MPFS is updated annually based on a formula defined by Medicare law and through a formal rulemaking proceeding.

The MPFS is based on the premise that if service "A" requires twice as many resources as service "B," service "A" should be paid twice as much as service "B." The payment amount for each service paid under the MPFS is the product of three factors:

- Relative Value Unit (RVU) for the service. From the simplest office visit to complex surgical procedures, the MPFS assigns RVUs that reflect the resources involved in completing the service and include:
    - Provider work component (the time, intensity, and technical skill required to furnish a service) which, in general, does not change from year to year except when CMS determines that the RVUs should be revised either on a case-by-case basis or as part of a statutorily required comprehensive five year review
    - Overhead component (all categories of practice expenses except for malpractice insurance costs) and
    - Malpractice expense component (the cost of obtaining malpractice insurance), which does not generally change from year to year except when CMS determines that the RVUs should be revised either on a case-by-case basis or as part of a statutorily required comprehensive five year review
- Geographic adjustment factor for each MPFS area, which recognizes that the costs incurred by providers vary depending on the location where they practice. The geographic adjustment factor is applied separately to each component (work, practice, and malpractice expense) of each service.
- Nationally uniform conversion factor for the service, which converts RVUs into payment amounts. Congress requires CMS to update the conversion factor annually according to a formula set by law.

The nonparticipating provider or supplier may choose to accept assignment of Medicare claims on a claim-by claim basis and may charge the beneficiary up to the limiting charge or the maximum amount that can be charged for the services furnished (unless prohibited by an applicable State law). The limiting charge is 115 percent of the MPFS amount.

The chart below depicts an example of a limiting charge.

Example of a Limiting Charge

Medicare Physician Fee Schedule Allowed Amount for Procedure "X"	$200.00
Nonparticipating Provider or Supplier Allowed Amount for Procedure "X"	$190.00 ($200.00 x .95 = 5 percent lower than Medicare Physician Fee Schedule allowed amount)
Limiting Charge for Procedure "X"	$218.50 ($190.00 x 1.15 = 115 percent of Medicare Physician Fee Schedule allowed amount)
Beneficiary Coinsurance and Limiting Charge Portion Due to Provider or Supplier	$66.50 ($38.00 plus $28.50) Coinsurance - 20 percent of Medicare Physician Fee Schedule allowed amount ($190.00 x .20 = $38.00) **PLUS** $218.50 limiting charge - 190.00 nonparticipating provider/supplier allowed amount $ 28.50 allowed amount

The limiting charge applies to the following regardless of who furnishes them or bills for them:

- Physicians' services;
- Services and supplies commonly furnished in physicians' offices that are incident to physicians' services;
- Outpatient PT and occupational therapy services furnished by an independently practicing therapist;
- Diagnostic tests; and
- Radiation therapy services including x-ray, radium, radioactive isotope therapy, materials, and technician services.

The chart below illustrates the payment amounts that participating and nonparticipating providers and suppliers receive.

Participating and Nonparticipating Provider/Supplier Payment Amounts

	Participating Provider/ Supplier	Nonparticipating Provider/Supplier Who Accepts Assignment	Nonparticipating Provider/Supplier Who Does Not Accept Assignment
Submitted Amount	$125.00	$125.00	$109.25
Medicare Physician Fee Schedule Allowed Amount	$100.00	$ 95.00	$ 95.00
80 Percent of Medicare Physician Fee Schedule Allowed Amount	$ 80.00	$ 76.00	$ 76.00
Beneficiary Coinsurance Due to Provider/Supplier (after deductible has been met)	$ 20.00	$ 19.00	$ 33.25
Total Payment to Provider/Supplier (payment for nonassigned claims goes to the beneficiary, who is responsible for paying the provider/supplier)	$100.00	$ 95.00	$109.25 ($95.00 x 1.15 – limiting charge)

Private Contracts with Medicare Beneficiaries

The following physicians who are legally authorized to practice medicine, surgery, dentistry, podiatry, or optometry by the state in which such function or action is performed may opt out of Medicare and privately contract with beneficiaries for the purpose of furnishing items or services that would otherwise be covered:

- Doctors of medicine;
- Doctors of osteopathy;
- Doctors of dental surgery or dental medicine;
- Doctors of podiatric medicine; and
- Doctors of optometry.

The following practitioners who are legally authorized to practice by the state and otherwise meet Medicare requirements may opt out of Medicare and privately contract with beneficiaries for the purpose of furnishing items or services that would otherwise be covered:

- PA;
- NP;
- CNS;
- CRNA;
- CNM;
- CP; and
- CSW.

The opt out period is for two years unless it is terminated early or the physician or practitioner fails to maintain opt out. Opt outs may be renewed for subsequent two-year periods. The physician or practitioner must opt out of Medicare for all beneficiaries and all items or services, with the exception of emergency or urgent care situations. In emergency or urgent care situations, the physician or practitioner may treat a beneficiary with whom he or she does not have a private contract and bill Medicare for the treatment. Claims for emergency or urgent care require modifier GJ ("OPT-OUT" physician or practitioner emergency or urgent service).

Medicare will make payment for covered medically necessary items or services that are ordered by a physician or practitioner who has opted out of Medicare if:

- He or she has acquired a UPIN; and
- The items or services are not furnished by a physician or practitioner who has also opted out of Medicare.

Protecting Your Practice

Engaging the Services of Billing Services or Consultants

Billing services or consultants may be engaged to submit claims to Medicare. Since providers and suppliers are responsible for any Medicare payments generated from claims submitted by billing services or consultants, they should complete the following activities:

- Review reports regarding claims billed to ensure consistency with their records; and
- Keep complete administrative records for seven years.

Providers and suppliers should ensure that billing services or consultants:

- Provide periodic reports regarding claims billed on their behalf, including how much Medicare paid if the billing service or consultant receives payments;
- Protect your identification numbers and any other information used to act on your behalf;
- Protect the confidentiality of patient data used in the submission of claims;
- Do not change procedure codes, diagnostic codes, or other information furnished by you or your organization without your knowledge and consent; and
- Provide all correspondence received from Medicare.

Hiring New Employees

When hiring new employees, providers and suppliers should:

- Select competent and ethical employees;
- Develop internal controls within the organization in order to minimize risk;
- Implement procedural checks and balances to ensure appropriate interactions with Medicare; and
- Conduct periodic quality checks of sensitive processes (e.g., the posting of account receivables).

Free or Discounted Services

If a provider or supplier furnishes free or discounted services (or a portion of free or discounted services), the services cannot be billed to Medicare or any secondary policy. It is unlawful to routinely waive the collection of deductibles, coinsurance, and copayments. If the patient is legitimately unable to pay for the services and this information is documented in the patient's records, the waiver of deductibles, coinsurance, and copayments is not considered unlawful.

Referrals

When a beneficiary requires a referral for specialized medical care or certain diagnostic tests or supplies, providers and suppliers should:

- Implement a process to ensure that only the services or tests ordered were furnished. For example, when reviewing the results of diagnostic tests, note whether additional or more complex tests were performed.
- Whenever possible, specify the reason the services are being ordered. For example, if diagnostic tests are ordered as part of a routine physical examination, the referral should include this information.
- Personally complete all medical information on referrals. Ensure that the patient's name and address is included on the referral before signing it. Never sign blank certification forms that justify Medicare payment for items such as home oxygen, wheelchairs, hospital beds, and prosthetic devices.
- Where applicable, specify the quantity of medical supplies that are needed.
- Be suspicious of entities that offer discounts, free services, or cash when ordering services.
- Never certify the need for medical supplies for patients who have not been seen and examined.

Contractual Arrangements

Providers and suppliers must consider numerous legal and compliance factors when they contract with individuals and other entities such as:

- The types of agreements and paperwork that must be executed;
- Ethical standards of conduct;
- State and Federal regulations; and
- Confidentiality obligations.

Compliance Programs

Implementing a compliance program can assist in establishing an environment that promotes prevention, detection, and resolution of conduct that does not conform to legal, ethical, or program requirements. Although compliance programs are strictly voluntary, adopting one may be beneficial to providers, suppliers, and other health care entities. The Office of Inspector General (OIG) has identified seven fundamental elements of an effective compliance program:

- Implementing written policies, procedures, and standards of conduct;
- Designating a compliance officer and compliance committee;
- Conducting effective training and education;
- Developing effective lines of communication;
- Enforcing standards through well-publicized disciplinary guidelines;
- Conducting internal monitoring and auditing;
- Responding promptly to detected offenses; and
- Developing a corrective action plan.

To find OIG compliance program guidance, visit *www.oig.hhs.gov/fraud/complianceguidance.html* and *www.gpoaccess.gov/fr* on the Web.

Promoting Cultural Competency and Enhancing Quality in Your Practice

The 2000 U.S. Census confirmed that our country is becoming increasingly diverse. Racial and ethnic minorities make up 30 percent of the American population and are expected to increase to 40 percent by 2030. Some 47 million U.S. residents speak a language other than English. With the increasing diversity of the U.S. population, providers and suppliers are more and more likely to encounter situations that require the delivery of culturally competent care, access to a vast array of language services, and supportive health care organizations. Addressing a patient's social and cultural background will assist providers and suppliers in delivering high quality, effective health care and increase patient satisfaction, improve patient compliance, and reduce racial and ethnic health disparities.

The HHS Office of Minority Health and Science Applications International Corporation have developed a free interactive web-based training cultural competency course titled *A Family Physician's Practical Guide to Culturally Competent Care*. The course assists physicians in preparing for the increasingly diverse patient population and furnishing the highest quality of care to every patient regardless of race, ethnicity, cultural background, or ability to speak English as their primary language. The course focuses on the following:

- Defining issues related to cultural diversity in medical practice;
- Identifying strategies to promote self-awareness about attitudes, beliefs, biases, and behaviors that may influence the clinical care physicians furnish;
- Devising strategies to enhance skills toward the provision of care in a culturally diverse clinical practice; and
- Demonstrating the advantages of the adoption of the National Standards of Culturally and Linguistically Appropriate Services (CLAS) in Health Care as appropriate in a clinical practice. The CLAS standards offer a framework and strategies to make practices more culturally and linguistically accessible.

Physicians can earn up to nine Category 1 Continuing Medical Education (CME) credits from the American Medical Association or nine CME credits from the American Academy of Family Physicians upon completion of the course. The course and CLAS standards are available at *http://thinkculturalhealth.org* on the Web.

To find additional information about how to become a Medicare provider or supplier, see the Medicare General Information, Eligibility, and Entitlement Manual (Pub. 100-1) located at *www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage* on the CMS website.

CHAPTER 3

MEDICARE REIMBURSEMENT

This chapter discusses how to receive reimbursement from the Medicare Program.

Medicare Claims

A claim is defined as a filing from a provider, supplier, or beneficiary that includes a request for Medicare payment and furnishes the Medicare Contractor with sufficient information to determine whether payment of benefits is due and the amount of payment.

Providers and suppliers who furnish covered services to Medicare patients on or after September 1, 1990 are required to submit claims for their services and cannot charge beneficiaries for completing or filing a Medicare claim. Medicare Contactors monitor compliance with these requirements. Offenders may be subject to a Civil Monetary Penalty of up to $10,000 for each violation.

Exceptions to Mandatory Filing

Providers and suppliers are not required to file claims on behalf of Medicare beneficiaries when:

- The claim is for services for which Medicare is the secondary payer, the primary insurer's payment is made directly to the beneficiary, and the beneficiary has not furnished the primary payment information needed to submit the Medicare secondary claim;
- The claim is for services furnished outside the U.S.;
- The claim is for services initially paid by third-party insurers who then file Medicare claims to recoup what Medicare pays as the primary insurer (e.g., indirect payment provisions);
- The claim is for other unusual services, which are evaluated by Medicare Contractors on a case-by-case basis;
- The claim is for excluded services (some supplemental insurers who pay for these services may require a Medicare claims denial notice prior to making payment);
- He or she has opted out of the Medicare Program by signing a private contract with the beneficiary; or
- He or she has been excluded or debarred from the Medicare Program.

In general, Medicare fee-for-service claims must be filed timely, which means that they must be filed on or before December 31 of the calendar year following the year in which the services were furnished. Services furnished in the last quarter of the year are considered furnished in the following year.

The chart below illustrates the timeframes for claims submission to Medicare.

FILING TIME LIMITS	
Claims With Dates Of Service	**Must Be Submitted By**
October 1, 2001 – September 30, 2002	December 31, 2003
October 1, 2002 – September 30, 2003	December 31, 2004
October 1, 2003 – September 30, 2004	December 31, 2005
October 1, 2004 – September 30, 2005	December 31, 2006
October 1, 2005 – September 30, 2006	December 31, 2007

Electronic Claims

All providers and suppliers, with the exception of those listed in the Paper Claims Section below, must submit claims electronically via Electronic Data Interchange (EDI) in the Health Insurance Portability and Accountability Act (HIPAA) format. Each provider or supplier must complete a Centers for Medicare & Medicaid Services (CMS) Standard EDI Enrollment Form and send it to the Medicare Contractor prior to submitting electronic media claims (EMC). A sender number, which is required in order to submit electronic claims, will then be issued. An organization that is comprised of multiple components that have been assigned Medicare legacy identifiers may elect to execute a single EDI Enrollment Form on behalf of the organizational components to which these numbers have been assigned. The EDI Enrollment Form can be found in the Medicare Claims Processing Manual (Pub. 100-04) located at *www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage* on the CMS website.

Electronic Media Claims Submissions

Claims are electronically transmitted to the Medicare Contractor's system, which verifies claim data. This information is then electronically checked or edited for required information. Claims that pass these initial edits, also called front-end or pre-edits, are processed in the claims processing system according to Medicare policies and guidelines. Claims with inadequate or incorrect information may be:

- Returned to the provider or supplier for correction;
- Suspended in the Contractor's system for correction; or
- Have information corrected by the system (in some cases).

A confirmation or acknowledgment report, which indicates the number of claims accepted and the total dollar amount transmitted, is generated to the provider or supplier. This report also indicates the claims that have been rejected and reason(s) for the rejection. The advantages of EMC submission include:

- Correctly filed claims can be paid 14 days after receipt, compared to the 29 days after receipt for payment of paper claims (effective January 1, 2006, the waiting period for payment of paper claims was extended);
- Elimination of mailroom processing; and
- Payment Contractor systems may provide notification of critical claim filing errors so that claims can be corrected before they enter the Medicare claims processing system.

Electronic Media Claims Submission Alternatives

Providers and suppliers who do not submit electronic claims using EMC may choose to alternatively submit claims:

- Through a software vendor, clearinghouse, or billing agent; or
- Using Medicare's free billing software.

Electronic versions of CMS claim forms can be found at *www.cms.hhs.gov/CMSForms/CMSForms/list.asp#TopOfPage* on the CMS website.

Paper Claims

For claims received on or after October 16, 2003, only the following providers and suppliers may submit paper claims, as mandated by HIPAA:

- Small Part A providers and suppliers who have fewer than 25 full-time equivalent employees;
- Providers and suppliers who have fewer than 10 full-time equivalent employees;
- Dentists;
- Participants in Medicare demonstration projects who require paper claim filing due to inability of the applicable Implementation Guide to report data essential for the demonstration;
- Providers and suppliers who conduct mass immunizations (e.g., flu injections) may submit paper roster claims;
- Providers and suppliers who submit claims when more than one other payer is responsible for payment prior to Medicare payment;
- Providers and suppliers who only furnish services outside the U.S.;
- Providers and suppliers who experience a disruption in electricity and communication connection that is beyond their control; and
- Providers and suppliers who can establish "unusual circumstances" that preclude submission of claims electronically.

Non-institutional providers and suppliers use the CMS-1500 claim form to bill Medicare Contractors and Durable Medical Equipment (DME) Medicare Administrative Contractors (MAC). CMS-1500 claim forms can be ordered from:

- U.S. Government Printing Office
  http://bookstore.gpo.gov
  Telephone: (866) 512-1800;
- Printing companies; and
- Office supply stores.

Institutional providers and suppliers use the CMS-1450, also known as UB-92, to bill Medicare Contractors. UB-92 claim forms can be ordered from:

National Uniform Billing Committee
www.nubc.org/guide.html
Telephone: (800) 242-2626

Effective May 23, 2007, a National Provider Identifier must be included on claim forms. Since the UB-92 does not have a field to report an NPI, it is being updated and replaced with the UB-04 claim form. CMS expects to discontinue acceptance of UB-92 forms effective May 23, 2007.

Durable Medical Equipment, Prosthetics and Orthotics, and Parenteral and Enteral Nutrition Claims

DME MACs have jurisdiction for following claims:

- Nonimplantable DME, prosthetics, orthotics, and supplies (including items for home use);
- Parenteral and enteral nutrition (PEN) products (other than items furnished to inpatients covered under Part A);
- Certain oral drugs billed by pharmacies; and
- Method II home dialysis.

Deductibles, Coinsurance, and Copayments

Providers and suppliers must collect unmet deductibles, coinsurance, and copayments from the beneficiary. The deductible is the amount the beneficiary must pay for health care before Medicare begins to pay, either for each benefit period for Part A or each year for Part B. These amounts can change every year. Coinsurance is the percent of the Medicare-approved amount that the beneficiary pays after he or she pays the plan deductible. In some Medicare plans, fixed amounts called copayments are paid by the beneficiary for each medical service. If a beneficiary is unable to pay these charges, he or she should sign a waiver that explains the financial hardship. If a waiver is not assigned, the beneficiary's medical record should reflect normal and reasonable attempts to collect the

charges before they are written off. The same attempts to collect charges must be applied to both Medicare beneficiaries and non-Medicare beneficiaries. Consistently waiving deductibles, coinsurance, and copayments may be interpreted as program abuse.

On assigned claims, the beneficiary is responsible for:

- Unmet deductibles;
- Applicable coinsurance and copayments; and
- Charges for services and supplies that are not covered by Medicare.

Coordination of Benefits

Coordination of Benefits (COB) is the process that determines the respective responsibilities of two or more health plans that have some financial responsibility for a medical claim. The COB Contractor completes activities that support the collection, management, and reporting of beneficiaries' other health care coverage that is primary to Medicare. The COB Contractor also has responsibility for consolidation of the claims crossover process, which ensures that all supplemental payers have the opportunity to receive Medicare processed claims from one source.

The table below describes some of the ways that the COB Contractor determines whether beneficiaries have other health care coverage that is primary to Medicare.

Determining Other Health Care Coverage

METHOD	DESCRIPTION
Initial Enrollment Questionnaire	Questionnaire that is sent to Medicare beneficiaries approximately three months before Medicare coverage begins regarding their other health insurance coverage
Internal Revenue Service, Social Security Administration, and Centers for Medicare & Medicaid Services Data Match	Questionnaire completed by employers regarding Group Health Plan coverage for identified workers who are either entitled to Medicare or are married to a Medicare beneficiary
Medicare Secondary Payer Claims Investigation	Collection of data regarding health insurance coverage that may be primary to Medicare based on information submitted on a medical claim or from other sources
Voluntary Medicare Secondary Payer Data Match Agreements	Agreements that allow for electronic data exchange of Group Health Plan eligibility and Medicare information between the Centers for Medicare & Medicaid Services and employers or insurers

Medicare Secondary Payer Program

Medicare law requires that providers and suppliers determine whether Medicare is the primary or secondary payer prior to submitting a claim. In addition, primary payers must be identified on claims submitted to Medicare. Providers and suppliers are required to ask beneficiaries or their representatives about other insurance for every admission, outpatient encounter, or start of care. The following secondary payer information can be found via the Medicare Secondary Payer (MSP) Auxiliary File in the Common Working File (CWF):

- MSP effective date;
- MSP termination date;
- Patient relationship;
- Subscriber name;
- Subscriber policy number;
- Insurer type;
- Insurer information (name, group number, address, city, state, and ZIP code);
- MSP type;
- Remarks code;
- Employer information (name, address, city, state, and ZIP code); and
- Employee information (identification number).

Providers and suppliers can have access to the CWF through a connection with their local Medicare Contractor. However, they should not rely on CWF information alone. Since MSP circumstances change quickly and CWF information may not be accurate, providers and suppliers should verify other health insurance information with the patient.

The benefits of the MSP Program include:

- Saves the Medicare Program over 4 billion dollars annually;
- Providers and suppliers who bill plans that are primary to Medicare may receive payment up to submitted charges. In many instances, plans that are primary pay more than the amount allowed under the Medicare Program; and
- Limits the beneficiary's out-of-pocket expenses.

The chart below depicts common situations when Medicare may pay first or second.

Common Situations When Medicare May Pay First or Second

If The Beneficiary	And This Condition Exists	Then This Program Pays First	And This Program Pays Second
Is age 65 or older and is covered by a Group Health Plan (GHP) through current employment or a spouse's current employment →	The employer has fewer than 20 employees →	**Medicare →**	GHP
	The employer has 20 or more employees or at least one employer is a multi-employer group that employs 20 or more individuals →	GHP →	**Medicare**
Has an employer retirement plan and is age 65 or older or is disabled and age 65 or younger →	The beneficiary is entitled to Medicare →	**Medicare →**	Retiree Coverage
Is disabled and covered by a Large Group Health Plan (LGHP) through his or her own current employment or through a family member's current employment →	The employer has fewer than 100 employees →	**Medicare →**	LGHP
	The employer has 100 or more employees, or at least one employer is a multi-employer group that employs 100 or more individuals →	LGHP →	**Medicare**
Has End-Stage Renal Disease (ESRD) and GHP coverage →	Is in the first 30 months of eligibility or entitlement to Medicare →	GHP →	**Medicare**
	After 30 months →	**Medicare →**	GHP
Has ESRD and Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage →	Is in the first 30 months of eligibility or entitlement to Medicare →	COBRA →	**Medicare**
	After 30 months →	**Medicare →**	COBRA
Is covered under Workers Compensation (WC) because of a job-related illness or injury →	The beneficiary is entitled to Medicare →	WC →	**Medicare**
Has black lung disease and is covered under the Federal Black Lung Program →	The beneficiary is eligible for the Federal Black Lung Program →	Federal Black Lung Program →	**Medicare**
Has been in an accident and no-fault or liability insurance is involved →	The beneficiary is entitled to Medicare →	No-fault or liability Insurance →	**Medicare**
Is age 65 or older or is disabled and covered by Medicare and COBRA →	The beneficiary is entitled to Medicare →	**Medicare →**	COBRA
Has Veterans Health Administration (VHA) benefits →	Received VHA authorized health care services at a non-VHA facility →	VHA →	**Medicare may pay when the services are Medicare covered services and are not covered by the VHA**

Medicare may make payment if the primary payer denies the claim and the provider or supplier includes documentation that the claim has been denied in the following situations:

- The Group Health Plan (GHP) denies payment for services because the beneficiary is not covered by the health plan;
- The no-fault or liability insurer denies payment or does not pay the bill because benefits have been exhausted;
- The Workers Compensation (WC) Plan denies payment (e.g., when it is not required to pay for certain medical conditions);
- The Federal Black Lung Program does not pay the bill;
- Benefits under the plan are exhausted for particular services;
- The services are not covered under the plan;
- A deductible applies; or
- The beneficiary is not entitled to benefits.

In liability, no-fault, or WC situations, Medicare may make a conditional payment for covered Medicare services in order to prevent beneficiary financial hardship when:

- The claim is not expected to be paid promptly within the specified time period for any reason except when the plan claims that its benefits are secondary to Medicare;
- The properly submitted claim was denied in whole or in part;
- Due to the physical or mental incapacity of the beneficiary, a proper claim was not filed with the primary insurer; or
- The beneficiary or provider/supplier who has accepted assignment filed a proper claim in whole or in part based on an assertion other than that the GHP or Large Group Health Plan is the secondary payer to Medicare.

When conditional payments are made under these situations, they are made on the condition that both the insurer and the beneficiary will reimburse Medicare to the extent that payment is subsequently made by the insurer.

Medicare Contractors process claims submitted for primary or secondary payment and can answer the following questions:

- Billing;
- Recovery; and
- Claim or service denials and adjustments.

The COB Contractor should be contacted regarding all other MSP inquiries at:

General written inquiries:
MEDICARE - Coordination of Benefits
P.O. Box 5041
New York, NY 10274-5041
Telephone: (800) 999-1118

Questionnaires and correspondence:
MEDICARE - COB
Data Match Project
P.O. Box 125
New York, NY 10274-0125

MEDICARE - COB
MSP Claims Investigation Project
P.O. Box 5041
New York, NY 10274-5041

MEDICARE - COB
Voluntary Agreement Project
P.O. Box 660
New York, NY 10274-0660

MEDICARE - COB
Initial Enrollment Questionnaire Project
P.O. Box 17521
Baltimore, MD 21203-7521

If Medicare processes and mistakenly makes primary payment and the provider or supplier receives primary payment from an insurance plan that is primary to Medicare, he or she must refund the payment to the Contractor.

To find additional information about MSP, see the Medicare General Information, Eligibility, and Entitlement Manual (Pub. 100-1) and the Medicare Secondary Payer Manual (Pub. 100-5) at *www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage* on the CMS website.

Incentive and Bonus Payments

Health Professional Shortage Area Incentive Payment
Effective January 1, 1991, under §1833(m) of the Social Security Act, Health Professional Shortage Area (HPSA) incentive payments will be paid to physicians who furnish medical care in geographic areas that have been designated as primary medical care HPSAs by the Health Resources and Services Administration (HRSA).

Under §413 of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003, beginning on January 1, 2005 HPSA incentive payments will be paid automatically for services furnished in full county primary care geographic area HPSAs and mental health HPSAs. Physicians will no longer need to identify that their services are furnished in a full county primary care geographic area HPSA. An automated file of HPSA designations will be updated on an annual basis, effective for services on or after January 1 of each calendar year. Physicians can self-designate throughout the year for newly designated HPSAs and HPSAs not included in the automated file based on the date of the data run used to create the file.

Psychiatrists who furnish services in mental health HPSAs with dates of service on or after January 1, 2004 are also eligible for the incentive payment. Physicians may be entitled to a 10 percent HPSA incentive payment and/or a 5 percent Physician Scarcity Area (PSA) bonus payment for the same service as long as the area where the service is performed meets both sets of criteria. The HPSA and PSA payments are based on the paid amount of the claim and are paid on a quarterly basis.

The QB modifier for a physician providing a service in a rural HPSA and the QU modifier for a physician providing a service in an urban HPSA must be submitted for the following ZIP code areas that:

- Do not fall within a designated full county HPSA;
- Do not fall within the county based on a determination of dominance made by the U.S. Postal Service;
- Are partially within a partial county HPSA; or
- Are designated after the annual update is made to the automated file.

Effective for claims with dates of service on or after January 1, 2006, the QB and QU modifiers will no longer be accepted. The AQ modifier (Physician providing a service in a Health Professional Shortage Area) will replace the QB and QU modifiers. Claims with prior dates of service must still be submitted with the QB and QU modifiers.

To determine if a modifier is needed, physicians should:

- Visit *www.cms.hhs.gov/HPSAPSAPhysicianBonuses* on the CMS website to find out whether the location where services are furnished is within a HPSA bonus area;
- Visit the U.S. Census Bureau website at *www.Census.gov* or the Federal Financial Institutions Examination Council website at *www.ffiec.gov/default.htm* to determine if the census tract where services are furnished is in an eligible HPSA; and
- Review letters of designation received from HRSA and verify eligibility of their area for a bonus with their Medicare Contractor before submitting services with a HPSA modifier. The letters of designation must be provided as documentation to the Contractor upon request.

To find additional information about HPSAs, visit *www.cms.hhs.gov/HPSAPSAPhysicianBonuses* and Chapter 12 of the Medicare Claims Processing Manual (Pub. 100-4) located at *www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage* on the CMS website.

Physician Scarcity Area Bonus Payment

The MMA provided a five percent incentive payment to physicians furnishing services in PSAs. As of January 1, 2005, Medicare pays primary care physicians who furnish services in a primary care scarcity county and specialty physicians who furnish services in a specialist care scarcity county an additional amount equal to five percent of the amount paid for their professional services under the Medicare Physician Fee Schedule. The Congress created the new incentive payment program to make it easier to recruit and retain both primary and specialist care physicians for furnishing services to Medicare beneficiaries in PSAs. A PSA is a U.S. county with a low ratio of primary care or specialty physicians to Medicare beneficiaries.

A primary care physician is defined as a:

- General practitioner;
- Family practice practitioner;
- General internist;
- Obstetrician; or
- Gynecologist.

A specialty care physician is defined as other than a primary care physician.

The following providers are not eligible for the specialty physician PSA bonus payment:

- Dentists;
- Chiropractors;
- Optometrists; and
- Podiatrists.

Section 413 of the MMA states that for physician professional services furnished on or after January 1, 2005 and before January 1, 2008, a PSA bonus payment will be available as follows:

- A 5 percent bonus payment (equal to 5 percent of the payment amount for the services furnished) will be available to primary and specialty physicians in counties (primary care or specialist care scarcity counties) with the lowest 20 percent ratio of primary care or specialty care physicians to Medicare eligible individuals residing in the county.
- To the extent that it is feasible, a rural census tract of a Metropolitan Statistical Area will be treated as an equivalent area for the purpose of qualifying as a primary care or specialist care scarcity county.
- The same services may qualify as a HPSA incentive payment and PSA bonus payment, resulting in a physician receiving a total 15 percent bonus payment as long as the area where the service is performed meets both sets of criteria.
- Determination of the bonus payment is made based on the ZIP code where the service was furnished. To find information about ZIP codes where automatic PSA payments will be made, visit *www.cms.hhs.gov/HPSAPSAPhysicianBonuses* on the CMS website.
- Bonus payments are made on a quarterly basis.
- The technical component of diagnostic services and services that are fully technical are not eligible for the bonus payment.

In some cases, a service may be furnished in a county that is considered a PSA, but the ZIP code is not considered dominant for that area. The bonus cannot be made automatically. In order to receive the bonus payment for these areas, physicians must include the AR modifier (Physician providing service in a Physician Scarcity Area) on the claim.

In order to be considered for the bonus payment, the name, address, and ZIP code of where the service was furnished must be included on all electronic and paper claim submissions.

To find additional information about PSAs, visit *www.cms.hhs.gov/HPSAPSAPhysicianBonuses* and Chapter 12 of the Medicare Claims Processing Manual (Pub. 100-4) located at *www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage* on the CMS website.

Medicare Notices

Advance Beneficiary Notice

An Advance Beneficiary Notice (ABN) is a written notice that a provider or supplier gives to a beneficiary before items or services are furnished to advise him or her that specified items or services may not be covered by Medicare. Providing an ABN allows the beneficiary to make an informed decision about whether to receive the item or service in question. In general, if a provider or supplier does not provide the beneficiary with an ABN, he or she cannot hold the beneficiary financially liable for the items or services if Medicare payment is denied or reduced. If the provider or supplier properly notifies the beneficiary that the items or services may not be covered, he or she may seek payment from the beneficiary. Providers and suppliers who furnish items or services to the beneficiary based on the referral or order of another provider or supplier are responsible for notifying the beneficiary that the services may not be covered by Medicare and that they can be held financially liable for the items or services if payment is denied or reduced. A copy of the ABN should be kept in the beneficiary's medical record. ABN forms can be found at *www.cms.hhs.gov/CMSForms/CMSForms/list.asp#TopOfPage* on the CMS website.

Certificate of Medical Necessity

A Certificate of Medicare Necessity (CMN) is included with claims for certain items that require additional information (e.g., DME and PEN). CMN forms can be found at *www.cms.hhs.gov/CMSForms/CMSForms/list.asp#TopOfPage* on the CMS website.

Notice of Exclusions from Medicare Benefits

The Notice of Exclusions from Medicare Benefits (NEMB) may be used to advise the beneficiary in advance that Medicare will not pay for certain items and services that do not meet the definition of a Medicare benefit or are specifically excluded by law. Providing a NEMB allows the beneficiary to make an informed decision about whether to receive items or services that he or she must pay for or that other health insurance may pay for. Providers and suppliers may use CMS NEMB forms, notices of their own design, or notices developed by professional associations. CMS NEMB forms can be found on at *www.cms.hhs.gov/CMSForms/CMSForms/list.asp#TopOfPage* on the CMS website.

Remittance Advice

A Remittance Advice (RA) is a notice of payments and adjustments that is sent to the provider, supplier, or biller. After a claim has been received and processed, the Medicare Contractor produces a RA which may serve as a companion to claim payments or as an explanation when there is no payment. The RA explains reimbursement decisions, including the reasons for payments and adjustments of processed claims. The RA features valid HIPAA codes and specific values that make up the claim payment. Some of these codes may identify adjustments, which refer to any changes that relate to how a claim is paid differently from the original billing. There are seven general types of adjustments:

- Denied claim;
- Zero payment;
- Partial payment;
- Reduced payment;
- Penalty applied;
- Additional payment; and
- Supplemental payment.

Medicare Summary Notice

Beneficiaries receive the Medicare Summary Notice (MSN), which lists all services or supplies that were billed to Medicare, on a monthly basis. The MSN replaces the Explanation of Your Medicare Part B Benefits, Medicare Benefit Notice (Part A), Explanation of Medicare Benefits (Part A), Notices of Utilization, and Benefit Denial letters. If a beneficiary disagrees with a claims decision, he or she has the right to file an appeal. See Chapter 7 for more information about appeals. To find information about the beneficiary notices initiative, visit *www.cms.hhs.gov/BNI* on the CMS website.

Other Health Insurance Plans

Medicare Advantage

Providers and suppliers that furnish services to a Medicare beneficiary who is enrolled in a Medicare Advantage (MA) Plan and do not have a contract with the MA Plan to furnish the services should bill the MA Plan. Prior to furnishing services to a MA Plan beneficiary under these circumstances, providers and suppliers should notify the beneficiary that he or she may be responsible for all charges for the health care services furnished.

Medicaid

Medicaid is a cooperative venture funded by Federal and State governments that pays for medical assistance for certain individuals and families with low incomes and limited resources. Within broad national guidelines established by Federal statutes, regulations, and policies, each state:

- Establishes its own eligibility standards;
- Determines the type, amount, duration, and scope of services;
- Sets the rate of payment for services; and
- Administers its own program.

The following Medicare premium and cost-sharing payment assistance may be available through the State Medicaid Program:

- Payment of Medicare Part A and Part B premiums, deductibles, coinsurance, and copayments for Qualified Medicare Beneficiaries (QMB) who:
  - Have resources that are at or below twice the standard allowed under the Social Security Income Program
  - Have incomes that are at or below 100 percent of the Federal poverty level (FPL) (payments are subject to limits that states may impose on payment rates)
- Payment of Part B premiums for Specified Low-Income Medicare Beneficiaries who:
  - Have resources similar to QMBs (as described above)
  - Have incomes that are below 120 percent of the FPL
- Payment of Part A premiums for Qualified Disabled and Working Individuals (QDWI) who:
  - Previously qualified for Medicare due to disability but lost entitlement because of their return to work (despite the disability)
  - Have incomes that are below 200 percent of the FPL
  - Do not meet any other Medicaid assistance category

QDWIs who do not meet these income guidelines may purchase Medicare Part A and Part B coverage.

Medicare covered services are paid first by the Medicare Program since Medicaid is always the payer of last resort.

Medigap

Medigap is a health insurance policy sold by private insurance companies to fill gaps in Original Medicare Plan coverage. Beneficiaries must be enrolled in Part A and Part B in order to purchase a Medigap policy and, under certain

circumstances, are guaranteed the right to buy a policy. Beneficiaries may authorize a reassignment of benefits on a claim-by-claim basis for participating providers and suppliers to file a claim for reimbursement of Medicare services and coinsurance amounts.

Railroad Retirement

Some Medicare beneficiaries who are retired railroad workers have supplementary medical insurance benefits from the Railroad Retirement Board (RRB). Paper RRB claims should be sent to:

Palmetto GBA
Railroad Medicare
P. O. Box 10066
Augusta, GA 30999

For information regarding electronic claims processing of RRB claims, call (866) 749-4301.

United Mine Workers of America

Some Medicare beneficiaries are members of the United Mine Workers of America (UMWA), which provides a health insurance plan for retired coal miners, spouses, and dependents. Paper UMWA claims should be sent to:

UMWA Health and Retirement Funds
P. O. Box 389
Ephraim, UT 84627-0631

For information regarding electronic claims processing, contact:

Envoy
Telephone: (800) 215-4730

Documentation

Medicare strives to minimize its documentation requirements for most services and to place no additional paperwork burden on providers and suppliers. Items and services should be documented as close as possible to the time they are furnished since late entries increase the likelihood of inaccuracies and may raise questions regarding the cause of the delay. The provider or supplier is responsible for all claims submitted on his or her behalf. Therefore, he or she should:

- Review coding manuals and Medicare publications to ensure proper code selection;
- Choose billing and revenue codes carefully;
- Ensure that codes are based on medical necessity;
- Ensure that office staff are knowledgeable about billing and coding principles if these responsibilities are delegated to them; and
- Conduct quality checks to ensure agreement with selected codes.

National Correct Coding Initiative

CMS developed the National Correct Coding Initiative (NCCI) to promote correct coding by providers and suppliers and ensure that appropriate payments are made for the services they furnish. NCCI applies to claims that contain more than one procedure that is:

- Performed on the same patient;
- On the same date of service; and
- By the same performing provider or supplier.

The following list provides examples of claim denials due to NCCI edits when one of the services should not have been reported on the claim:

- Two procedures are reported that could not possibly have been reported together. For example, reporting the removal of an organ through both an open incision and via laparoscopy.
- Both female and male specific codes for a single patient, on the same date of service, and by the same performing provider or supplier is reported. For example, reporting a cystourethroscopy, with internal urethrotomy of both a female and a male.
- One or more components of a comprehensive service is reported when a single code is available that describes the complete service. For example, separate codes are individually reported to describe the removal of the uterus, ovaries, and fallopian tubes when a single code describes the removal of the organs.
- Both extensive and limited procedures are reported. For example, reporting that both a deep and a superficial biopsy is performed at the same location.
- Two procedures are reported together for which there is a third separate code that describes the combination of services. For example, right heart catheterization and retrograde left heart catheterization are reported when a separate code describes the combined procedures.

The *National Correct Coding Policy Manual in Comprehensive Code Sequence for Part B Medicare Carriers* is available from the National Technical Information Service (NTIS) at:

NTIS Subscriptions Department
5285 Port Royal Road
Springfield, VA 22161
www.ntis.gov/help/subscriptions.asp
Telephone: (800) 363-2068

Providers and suppliers who disagree with an edit should contact:

Correct Coding Initiative
AdminaStar Federal, Inc.
P. O. Box 50469
Indianapolis, IN 46250-0469
Telephone: (317) 841-4600

For additional information about NCCI edits, visit *www.cms.hhs.gov/NationalCorrectCodInitEd* on the CMS website.

Comprehensive Error Rate Testing Program

The purpose of Comprehensive Error Rate Testing (CERT) Program is to measure and improve the quality and accuracy of Medicare claims submission, processing, and payment. Over 140,000 randomly-selected claims are reviewed each year in order to characterize and quantify local, regional, and national error rate patterns. The CERT Contractor may request additional information related to a claim (e.g., medical records or a CMN). This documentation is used to verify that the claim complies with coverage, billing, and coding rules and that the claim was processed correctly by the Medicare Contractor. If the requested information is not received within 90 days, CERT operations will assume that the services were not furnished and the claim submission will be registered as erroneous. To find additional information about CERT, visit *www.cms.hhs.gov/CERT* on the CMS website.

To find additional information about Medicare reimbursement, see the Medicare Claims Processing Manual (Pub. 100-4) located at *www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage* on the CMS website.

CHAPTER 4

MEDICARE PAYMENT POLICIES

This chapter discusses Medicare payment policies.

Services That Medicare DOES Pay For

In general, Medicare pays for services that are considered medically reasonable and necessary to the overall diagnosis and treatment of the patient's condition. Services or supplies are considered medically necessary if they:

- Are proper and needed for the diagnosis or treatment of the patient's medical condition;
- Are furnished for the diagnosis, direct care, and treatment of the patient's medical condition;
- Meet the standards of good medical practice; and
- Are not mainly for the convenience of the patient, provider, or supplier.

For every service billed, the provider or supplier must indicate the specific sign, symptom, or patient complaint necessitating the service. Although furnishing a service or test may be considered good medical practice, Medicare generally prohibits payment for services without patient symptoms or complaints.

Medicare pays for provider professional services that are furnished in:

- The U.S. (the Centers for Medicare & Medicaid Services [CMS] recognizes the 50 states, the District of Columbia, Commonwealth of Puerto Rico, Virgin Islands, Guam, Northern Mariana Islands, American Samoa, and territorial waters adjoining the land areas of the U.S. as being within the U.S.); and
- The home, office, institution, or at the scene of an accident.

Covered Part A Inpatient Hospital Services

Subject to certain conditions, limitations, and exceptions the following inpatient hospital or inpatient Critical Access Hospital (CAH) services are furnished to an inpatient of a participating hospital or participating CAH or, in the case of emergency services or services in foreign hospitals, to an inpatient of a qualified hospital:

- Bed and board;
- Nursing and other related services;
- Use of hospital or CAH facilities;
- Medical social services;
- Drugs, biologicals, supplies, appliances, and equipment;
- Certain other diagnostic or therapeutic services;
- Medical or surgical services furnished by certain interns or residents in training; and
- Transportation services including transport by ambulance.

An inpatient is an individual who has been admitted to a hospital for the purpose of receiving inpatient hospital services. Generally, a patient is considered an inpatient if he or she is formally admitted as inpatient with the expectation of remaining at least overnight and occupying a bed. The patient is considered an inpatient even if he or she can later be discharged or transferred to another hospital and does not actually use a hospital bed overnight.

The physician or other practitioner responsible for a patient's care at the hospital is responsible for deciding whether the patient should be admitted as an inpatient. The physician or other practitioner should work closely with hospital staff to ensure a proper admission as an inpatient following hospital admission protocols. The physician or practitioner should also use a 24-hour period as a benchmark by ordering admission for patients who are expected to need hospital care for 24 hours or more and treating other patients on an outpatient basis. The decision to admit a patient is a complex medical judgment that requires the consideration of:

- The patient's medical history and current medical needs, including the severity of the signs and symptoms exhibited;
- The medical predictability of something adverse happening to the patient;
- The need for diagnostic studies that will assist in assessing whether the patient should be admitted and that do not ordinarily require him or her to remain at the hospital for 24 hours or more;
- The availability of diagnostic procedures at the time when and where the patient presents;
- The types of facilities available to inpatients and outpatients;
- The hospital's by-laws and admissions policies; and
- The relative appropriateness of treatment in each setting.

In the following situations, coverage of services on an inpatient or outpatient basis is not determined solely on the basis of length of time the patient actually spends in the hospital:

Minor Surgery or Other Treatment

When a patient with a known diagnosis enters a hospital for a specific minor surgical procedure or other treatment that is expected to keep him or her in the hospital for less than 24 hours, for coverage purposes he or she is considered an outpatient regardless of the arrival hour at the hospital, use of a bed, or if he or she remains in the hospital past midnight.

Renal Dialysis Treatments

Renal dialysis treatments are usually covered only as outpatient services for the patient who:

- Resides at home;
- Is ambulatory;
- Has stable conditions; and
- Comes to the hospital for routine chronic dialysis treatments (not for a diagnostic workup or a change in therapy).

The renal dialysis patient with one of the following conditions is usually an inpatient:

- He or she is undergoing short-term dialysis until the kidneys recover from an acute illness (acute dialysis); or
- He or she has borderline renal failure and develops acute renal failure every time he or she has an illness and requires dialysis (episodic dialysis).

A patient may begin dialysis as an inpatient and then progress to outpatient status. If noncovered services that are generally excluded from Medicare coverage are furnished in Non-Prospective Payment Systems hospitals, part of the billed charges or the entire admission may be denied. Appropriately admitted cases in Prospective Payment System (PPS) hospitals include the following:

- If care is noncovered because a patient does not need to be hospitalized, the admission will be denied and the Part A PPS payment will be made only under limitation on liability. Under limitation on liability, Medicare payment may be made when the provider and the patient were unaware that the services were not necessary and could not reasonably be expected to know that they were not necessary. If a patient is appropriately hospitalized but receives only noncovered care (beyond routine services), the admission is denied. An admission that includes covered care, even if noncovered care was also furnished, will not be denied. Under PPS, Medicare assumes that it is paying for only the covered care furnished when covered services needed to treat and/or diagnose the illness are furnished.
- If a noncovered procedure is furnished along with covered nonroutine care, a Diagnosis Related Group change rather than an admission denial might occur. If noncovered procedures elevate costs into the cost outlier category, outlier payment will be denied in whole or in part.

- If a patient receives items or services in excess of, or more expensive than, those for which payment can be made, payment is made only for the covered items or services or the appropriate PPS amount. This provision applies to inpatient services as well as all hospital services under Parts A and B of the Medicare Program. If items or services are requested by the patient, the hospital may charge him or her the difference between the amount customarily charged for the services requested and the amount customarily charged for covered services.

If a patient requires extended care services and is admitted to a bed in a hospital, he or she is considered an inpatient of the hospital. The services furnished in the hospital will not be considered extended care services and payment may not be made unless the services are extended care services furnished pursuant to a swing bed agreement granted to the hospital by the Secretary of Health and Human Services (HHS).

Covered Part B Services

Covered Part B services include, but are not limited to, the following:

- Physician services such as surgery, consultations, office visits, institutional calls;
- Services and supplies furnished incident to physician's professional services;
- Outpatient hospital services furnished incident to physician services;
- Outpatient diagnostic services furnished by a hospital;
- Outpatient physical therapy (PT) services;
- Outpatient occupational therapy (OT) services;
- Outpatient speech-language pathology (SLP) services;
- Diagnostic x-ray tests, laboratory tests, and other diagnostic tests;
- X-ray, radium, and radioactive isotope therapy services;
- Surgical dressings and splints, casts, and other devices used for reduction of fractures and dislocations;
- Rental or purchase of durable medical equipment for use in the patient's home;
- Ambulance services;
- Certain prosthetic devices that replace all or part of an internal body organ;
- Leg, arm, back, and neck braces and artificial legs, arms, and eyes;
- Certain medical supplies used in connection with home dialysis delivery systems; and
- Ambulatory Surgical Center services.

Incident to Provision

To be covered incident to the services of a physician, services and supplies must meet the following four requirements:

1) Commonly furnished in physicians' offices or clinics

Services and supplies commonly furnished in physicians' offices are covered under the incident to provision. Charges for these services and supplies must be included in the physician's bill. To be covered, supplies, including drugs and biologicals, must be an expense to the physician or legal entity billing for the services or supplies.

2) Furnished by the physician or auxiliary personnel under the direct personal supervision of a physician

Services billed as incident to the physician may be furnished by auxiliary personnel or nonphysician practitioners (NPP) under the required level of supervision. Auxiliary personnel are individuals who act under the supervision of a physician regardless of whether the individual is an employee, leased employee, or independent contractor of the physician or of the legal entity that employs or contracts with the physician. A physician may also have the services of certain NPPs covered as incident to his or her professional service. These NPPs include the following:

- Certified nurse midwives (CNM);
- Certified registered nurse anesthetists (CRNA);
- Physical therapists (PT);
- Occupational therapists;
- Clinical psychologists (CP);
- Clinical social workers (CSW);
- Physician assistants (PA);
- Nurse practitioners (NP);
- Clinical nurse specialists (CNS); and
- Audiologists.

The direct supervision for any service, including evaluation and management (E/M) services, can be provided by any member of the group who is physically present on the premises and is not limited to the physician who has established the patient's plan of care.

Direct supervision in the office setting means that the physician is present in the office suite and immediately available to furnish assistance and direction throughout the performance of the service.

Services furnished by auxiliary personnel outside the office setting (e.g., in a patient's home or in an institution other than a hospital or Skilled Nursing Facility [SNF]) are covered incident to a physician's service only if there is personal supervision by the physician. Personal supervision means that a physician is physically in attendance in the same room during the performance of the procedure.

3) Commonly furnished without charge or included in the physician's bill

Incident to services or supplies must represent an expense incurred by the physician or legal entity billing for the services or supplies.

4) An integral, although incidental, part of the physician's professional service

The physician must have furnished a personal professional service to initiate the course of treatment that is being furnished by the NPP as an incidental part. There must also be subsequent service by the physician of a frequency that reflects the physician's continuing active participation in, and management of, the course of treatment. The physician or another physician in the group practice must be physically present in the same office suite and immediately available to render assistance, if necessary.

Although the rehabilitative services of PT, OT, and SLP have their own benefits under the law, it is also acceptable for these services to be billed by physicians incident to their services if the rules for both the therapy benefit and the incident to benefit are met, with one exception. The staff who provide therapy services under the direct supervision of a physician must be qualified as therapists with the exception of any licensure requirements that may apply. For example, PTs must be licensed and graduates of an approved PT curriculum (unless they meet other requirements for foreign or pre-1977 training). Staff who provide PT services must be graduates of an approved PT curriculum, but not necessarily licensed.

The patient record should document the essential requirements for incident to services.

Commonly Furnished Services

Consultations

Consultations are primarily performed at the request of a referring physician or practitioner in order to provide him or her with advice or an opinion. The following guidelines apply to consultations:

- The consultant examines the patient, prepares a written report that details his or her findings, and forwards the report to the referring provider;
- If the intent of the consultation is to see the patient and provide the referring physician or practitioner with advice or an opinion, consultation procedure codes must be included on the claim;
- A consultant may initiate diagnostic treatments and/or therapeutic services;
- If the consultant assumes responsibility for the patient, he or she should use appropriate procedure codes for established or subsequent patient visits based on the place of service;
- All consultation codes billed to Medicare must contain the referring physician's name and Unique Physician/Practitioner Identification Number (UPIN);
- A consultation may also be initiated by the patient and/or a family member in order to obtain a second or third opinion, in which case the physician who performs the consultation should enter his or her name and UPIN on the claim form; and
- Any identifiable procedure or service performed on or subsequent to the date of the initial consultation should be reported separately.

Medical record documentation requirements for consultations include:

- History, examination, and medical decision making components must support the level of care billed;
- The referring provider documents the request and need for advice or an opinion in the patient's medical record;
- The consultant documents his or her advice or an opinion and any services or tests furnished in the patient's medical record; and
- The consultant provides a written report to the referring physician or qualified NPP.

Concurrent care occurs when certain E/M services are furnished by more than one physician with the same or similar specialty on the same date of service. Reasonable and necessary services of each physician who furnish concurrent care may be covered when each is required to play an active role in the patient's course of treatment. Some medical conditions may exist that require diverse specialized medical services. For example, although cardiology is a subspecialty of internal medicine, the treatment of both diabetes and a serious heart condition

may require the concurrent services of two physicians who practice internal medicine but have different subspecialties. Coverage guidelines for concurrent physician services include:

- The patient's medical condition must warrant the services of more than one physician with the same or similar specialty on an attending, rather than consultative, basis;
- The individual services furnished by each physician must be reasonable and necessary;
- The services of two physicians with the same specialty or subspecialty may be required if one physician has limited his or her practice to a unique aspect of that specialty; and
- Medical record documentation must substantiate the need for more than one physician's services.

Diagnostic Tests

Diagnostic tests assist in identifying the nature and underlying cause of illness and may be:

- Personally performed by the physician;
- Performed under the physician's direct supervision by his or her employee; or
- Purchased.

Purchased tests are administered by a supplier's personnel at the physician's office or at another location and are not personally performed by the physician or his or her employee under his or her direct supervision. The definition of a purchased test is not affected by the physician's financial interest in the supplier.

A diagnostic test may be billed in one of the following ways:

- Globally: the same physician performs the test and interprets the results. When billing globally, the physician must either:
    - Personally perform both the professional and the technical components of the test
    - Personally perform the professional component and supervise his or her employee who performs the technical component
- Technical component only: the diagnostic test is performed but not interpreted by the physician. The modifier TC (technical component) is indicated on the claim form to identify these services.
- Professional component only: the physician interprets but does not perform the technical component of the test. The modifier 26 (professional component) is indicated on the claim form to identify these services.

- Purchased technical component: purchased technical component is purchased from an outside supplier and is submitted as a separate item on the claim form. If more than one supplier is used or more than one test is purchased, separate claims must be submitted.
- Purchased professional component: a purchased professional or interpretation component is purchased from an independent physician or medical group. The following guidelines apply to purchased professional component tests:
    - Must be initiated by a physician or medical group that is independent of the physician or medical group furnishing the interpretation
    - The physician or medical group that purchased the interpretation submits the claim form, which must include the following:
        - The name, address, and Medicare Provider Identification Number (PIN) of the physician or medical group that furnishes the interpretation of the test
        - The ordering physician's name and UPIN
        - The acquisition cost or amount paid for the service
    - The interpreting physician or medical group must be enrolled in the Medicare Program
    - The physician or medical group that furnishes the interpretation does not see the patient
    - The purchaser (employee, partner, or owner of the purchaser) of the interpretation performs the technical component of the diagnostic test and
    - The purchaser must keep the interpreting physician's name, address, and PIN on file

Hospice

Hospice care is covered under Part A for the terminally ill beneficiary who meets all of the following conditions:

- The individual is eligible for Part A;
- The individual is certified as having a terminal disease with a prognosis of six months or less if the illness runs its normal course;
- The individual receives care from a Medicare-approved hospice program; and
- The individual signs a statement indicating that he or she elects the hospice benefit and waives all rights to Medicare payments for services for the terminal illness and related conditions. Medicare will continue to pay for covered benefits that are not related to the terminal illness.

Medicare may provide the following hospice services for the terminal illness and related conditions:

- Doctor services;
- Nursing care;
- Medical equipment;
- Medical supplies;
- Drugs for symptom control or pain relief;
- Home health aid and homemaker services;
- PT;
- OT;
- SLP;
- Social worker services;
- Dietary counseling;
- Spiritual counseling;
- Grief and loss counseling for the individual and his or her family; and
- Short-term care in the hospital, including respite care.

Medicare will NOT pay for the following services when hospice care is chosen:

- Treatment intended to cure the terminal illness;
- Care from any provider that was not set up by the elected hospice;
- Care from another provider that is the same care that the individual must receive from his or her hospice;
- Services not covered by Medicare; and
- Services that are not medically reasonable and necessary.

Hospice care is available for 2 periods of 90 days and an unlimited number of 60 day periods. The medical director of the hospice or the physician member of the hospice and interdisciplinary group and the individual's attending physician, if the individual has an attending physician, are required for the initial certification of the terminal illness. To be eligible for the Medicare hospice benefit, a beneficiary requires certification of the terminal condition with a prognosis of six months or less if the disease runs its normal course. Certification is required at the initiation of the benefit period and for each subsequent benefit period. If the individual lives longer than six months, he or she is still eligible for hospice care as long as there is recertification of the terminal illness.

Injections, Drugs, and Biologicals

With the exception of influenza, pneumococcal polysaccharide, and Hepatitis B vaccinations, injections fall within one of the following categories:

- Covered injections for drugs being used for an accepted indication that are not usually self administered and are furnished as the only service to the patient: Bill the procedure code for the administration and bill the procedure code for the drug;
- Covered injections for drugs being used for an accepted indication that are not usually self administered and are furnished during the course of an E/M service: Bill the procedure code for an E/M service and bill the procedure code for the drug; or
- Excluded injections: Medicare does not pay for either the administration of the drug or the drug.

See the Preventive Services Section below for information about influenza, pneumococcal polysaccharide, and Hepatitis B vaccinations.

Outpatient Observation

A patient is considered an outpatient if a physician orders that he or she be placed under observation. The purpose of observation is to determine the need for further treatment or inpatient admission. Observation services are furnished by a hospital on the hospital's premises and include:

- The use of a bed;
- Periodic monitoring by the hospital's nursing or other staff; and
- The services that are reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible admission to the hospital as an inpatient.

Observation services are covered only when they are furnished by the order of a physician or other individual who is authorized by State licensure law and hospital staff by-laws to admit patients to the hospital or order outpatient tests, generally within a 24-hour period and rarely, in exceptional circumstances, within a 48-hour period.

If a hospital intends to place or retain a patient in observation for a noncovered service, it must give the patient proper written advance notice of noncoverage under limitation on liability procedures. The following are not covered as outpatient observation services:

- Services that are not reasonable and necessary for the diagnosis or treatment of the patient and are furnished for the convenience of the patient, the patient's family, or the physician;
- Services that are covered under Part A;
- Services that are part of another Part B service; and
- Standing orders for observation following outpatient surgery.

Preventive Services

The coverage of certain preventive services has been mandated by the Balanced Budget Act of 1997, Benefits Improvement and Protection Act of 2000, and the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003. Preventive screenings and services, early detection of disease, and disease management along with professional advice on diet, exercise, weight control, and smoking cessation can help beneficiaries lead healthier lives and prevent, delay, or lessen the impact of disease.

The MMA expanded Part B coverage of preventive services to include an initial preventive physical examination (IPPE), cardiovascular screening blood tests, and diabetes screening tests as described below.

Initial Preventive Physical Examination (also known as the "Welcome to Medicare Physical")

All beneficiaries enrolled in Part B with effective dates that begin on or after January 1, 2005 are eligible for the IPPE benefit. This one-time benefit must be received by the beneficiary within the first six months of Part B coverage. An IPPE consists of all seven of the following components (components must either be furnished or some furnished and some referred):

- Review of the beneficiary's medical and social history, with attention to modifiable risk factors;
- Review of the beneficiary's risk factors for depression;
- Review of the beneficiary's functional ability and level of safety;
- An examination that includes the beneficiary's height, weight, blood pressure measurement, and visual acuity screen;
- Performance and interpretation of an electrocardiogram;
- Education, counseling, and referral based on the results of the review and evaluation services described in the previous five elements; and
- Education, counseling, and referral that includes providing the beneficiary with a brief written plan for obtaining the appropriate screenings and other preventive services that are covered as separate Part B benefits.

The physician, qualified NPP, or hospital may furnish the IPPE and bill Part B separately for it and other preventive services. The IPPE does not include any clinical laboratory tests.

The following should be documented in the beneficiary's medical record:

- That each component of the IPPE was either furnished or some were furnished and some were referred;
- The separate, medically necessary E/M services that were furnished; and
- All referrals and a written medical plan.

The beneficiary is responsible for paying the coinsurance or copayment associated with receiving an IPPE after he or she has met the yearly Part B deductible. The deductible does not apply to beneficiaries who receive an IPPE in a Federally Qualified Health Center (FQHC).

Cardiovascular Screening Blood Tests

For services furnished on or after January 1, 2005, the following cardiovascular screening blood tests for the early detection of cardiovascular disease or abnormalities associated with an elevated risk of heart disease and stroke are covered for all asymptomatic beneficiaries once every five years (at least 59 months after the last covered screening tests):

- Total cholesterol;
- High-density lipoproteins; and
- Triglycerides.

The following information must be included in the beneficiary's medical record:

- The screening test was ordered by a physician or qualified NPP;
- The beneficiary is asymptomatic;
- The purpose of the screening test is for early detection of cardiovascular disease;
- The test was performed after a 12-hour fast; and
- Appropriate supporting procedure and diagnosis codes.

The beneficiary pays no deductible, coinsurance, or copayment for these cardiovascular screening blood tests.

Diabetes Screening Tests

For services furnished on or after January 1, 2005, Medicare covers diabetes screening tests with a referral from a physician or qualified NPP as follows:

- Beneficiaries who are non-diabetic and not previously diagnosed as pre-diabetic may receive one diabetes screening test within a 12-month period (at least 11 months have passed following the month in which the last covered diabetes screening test was performed).
- Beneficiaries who have any of the following may receive a maximum of two diabetes screening tests within a 12-month period (but not less than 6 months apart):
    1) Diagnosed with pre-diabetes
    2) Have any of the following risk factors:
        - Hypertension
        - Dyslipidemia (history of abnormal cholesterol and triglyceride levels)
        - Obesity (a body mass index greater than or equal to 30kg/m^2) or
        - Previous identification of an elevated impaired fasting glucose or impaired glucose tolerance
    3) Have a risk factor for diabetes consisting of at least two of the following characteristics:
        - Overweight (a body mass index greater than 25 but less than 30kg/m^2)
        - A family history of diabetes (parents, brothers, or sisters)
        - Age 65 or older
        - A history of gestational diabetes mellitus or delivery of a baby weighing greater than 9 pounds

Covered diabetes blood screening tests include:

- Fasting blood glucose; and
- Post-glucose challenge, not limited to:
    - Oral glucose tolerance with a glucose challenge of 75 grams of glucose for non-pregnant adults or
    - 2-hour post-glucose challenge test alone

The beneficiary pays no deductible, coinsurance, or copayment for these diabetes screening tests.

Other preventive services covered under Part B are discussed below.

Diabetes Self-Management Training Services

Diabetes self-management training (DSMT) services are covered for beneficiaries who:

- Have recently been diagnosed with diabetes;
- Have been determined to be at risk for complications from diabetes; or
- Were diagnosed with diabetes before meeting Medicare eligibility requirements and have since become eligible for coverage.

A qualified DSMT program includes:

- Instruction on self-monitoring of blood glucose;
- Education about diet and exercise;
- An insulin treatment plan developed specifically for insulin dependent patients; and
- Motivation for patients to use the skills for self-management.

Individuals who have been impacted by any of the following situations may benefit from receiving DSMT services:

- Problems controlling blood sugar;
- Beginning diabetes medication or switching from oral diabetes medication to insulin;
- Diagnosed with eye disease related to diabetes;
- Lack of feeling in feet or other foot problems such as ulcers or deformities or an amputation was performed;
- Treated in an emergency room or has stayed overnight in a hospital because of diabetes; or
- Diagnosed with kidney disease related to diabetes.

DSMT services are covered by Medicare only if the physician or qualified NPP who is managing the beneficiary's diabetic condition certifies that the services are needed under a comprehensive plan of care. The plan of care must be written and signed by the physician or qualified NPP, be reasonable and necessary, and include the following information:

- Number of sessions (up to 10 hours), frequency, and duration of the training;
- Topics to be covered in training (initial training hours can be used to pay for the full program curriculum or specific areas such as nutrition or insulin training);
- A determination regarding whether the beneficiary should receive individual or group training; and
- Any changes to the plan of care, if applicable.

Additional DSMT services coverage requirements include that the DSMT program must:

- Be accredited by the American Diabetes Association (ADA) or Indian Health Service (IHS);
- Provide services to eligible Medicare beneficiaries that are diagnosed with diabetes; and
- Submit an accreditation certificate from the ADA, IHS, or another CMS-recognized program to the local Medicare Contractor's provider enrollment department.

The provider of DSMT services must maintain documentation in the beneficiary's medical record that includes the original order from the physician and any special conditions noted by the physician.

The beneficiary is responsible for paying the coinsurance or copayment for DSMT services after he or she has met the yearly Part B deductible.

Medical Nutrition Therapy

The following medical nutrition therapy (MNT) services are covered for beneficiaries who have been diagnosed with diabetes or a renal disease and the physician has prescribed and provided a referral for the services:

- An initial nutrition and lifestyle assessment;
- Nutrition counseling;
- Information about managing lifestyle factors that affect diet; and
- Follow-up sessions to monitor progress.

Duration and frequency limit guidelines that apply to MNT services include:

- Three hours of one-on-one counseling services for the first year;
- Two hours of coverage for subsequent years;
- The dietician or nutritionist may choose how many units are provided per day;
- Additional hours may be covered if the physician orders additional hours of MNT based on a change in medical condition, diagnosis, or treatment regimen; and
- The physician must prescribe the services and renew the referral for services on a yearly basis.

MNT services must be furnished by one of the following providers:

- Qualified dietitian;
- Licensed registered dietitian;
- Licensed nutritionist who meets the registered dietitian requirement; or
- Grandfathered nutritionist who was licensed as of December 12, 2000.

The beneficiary is responsible for paying the coinsurance or copayment for MNT services after he or she has met the yearly Part B deductible.

Screening Pap Test

Medicare provides coverage of a screening Pap test for all female beneficiaries when the test is ordered and collected by a doctor of medicine, doctor of osteopathy, CNM, PA, NP, or CNS who is authorized under State law to perform the examination based on one of the following guidelines:

- Once every 12 months (at least 11 months have passed following the month that the last covered Pap test was performed) when there is evidence:
    - That the woman (on the basis of her medical history or other findings) is of childbearing age and has had an examination that indicates the presence of cervical or vaginal cancer or other abnormalities during any of the preceding 3 years
    - That the woman is in one of the high risk categories for developing cervical or vaginal cancer or other specified personal history presenting hazards to health
- Once every 24 months (at least 23 months have passed following the month in which the last covered screening Pap test was performed):
    - For all other female beneficiaries who are at low risk for developing cervical or vaginal cancer

The high risk factors for cervical cancer include:

- Early onset of sexual activity (under 16 years of age);
- Multiple sexual partners (5 or more in a lifetime);
- History of a sexually transmitted disease, including Human Papillomavirus (HPV) and/or Human Immunodeficiency Virus (HIV) infection; and
- Fewer than 3 negative Pap tests within the previous 7 years.

The high risk factors for vaginal cancer include:

- Diethylstilbestrol (DES)-exposed daughters of women who took DES during pregnancy.

The beneficiary is responsible for paying the coinsurance or copayment for the Pap test collection. There is no Part B deductible for the Pap test collection. The beneficiary pays no deductible, coinsurance, or copayment for the Pap laboratory test.

Screening Pelvic Examination

Medicare provides coverage of screening pelvic examinations for all female beneficiaries when they are furnished by a doctor of medicine, doctor of osteopathy, CNM, PA, NP, or CNS who is authorized under State law to perform the examination. Pelvic screening examinations do not have to be ordered by a physician or other authorized practitioner and are covered based on one of the following guidelines:

- Once every 12 months (at least 11 months have passed following the month in which the last covered pelvic examination was performed) when one or both of the following criteria are met:
    - There is evidence that the beneficiary is in one of the high risk categories for developing cervical or vaginal cancer or other specified personal history that presents a hazard to health and/or
    - A beneficiary of childbearing age has had an examination that indicated the presence of cervical or vaginal cancer or other abnormality during the preceding 3 years
- Once every 24 months (at least 23 months have passed following the month in which the last covered pelvic examination was performed) for:
    - All other female beneficiaries

The high risk factors for cervical cancer include:

- Early onset of sexual activity (under 16 years of age);
- Multiple sexual partners (5 or more in a lifetime);
- A history of a sexually transmitted disease, including HPV and/or HIV infection; and
- Fewer than 3 negative Pap tests within the previous 7 years.

The high risk factors for vaginal cancer include:

- DES-exposed daughters of women who took DES during pregnancy.

A screening pelvic examination should include at least seven of the following elements:

- Inspection and palpation of breasts for masses or lumps, tenderness, symmetry, or nipple discharge;
- Digital rectal examination including sphincter tone, presence of hemorrhoids, and rectal masses; and

- Pelvic examination (with or without specimen collection for smears and cultures) including:
    - External genitalia (general appearance, hair distribution, or lesions)
    - Urethral meatus (size, location, lesions, or prolapse)
    - Urethra (masses, tenderness, or scarring)
    - Bladder (fullness, masses, or tenderness)
    - Vagina (general appearance, estrogen effect, discharge lesions, pelvic support, cystocele, or rectocele)
    - Cervix (general appearance, discharge, or lesions)
    - Uterus (size, contour, position, mobility, tenderness, consistency, descent, or support)
    - Adnexa/parametria (masses, tenderness, organomegaly, or nodularity)
    - Anus and perineum

The beneficiary is responsible for paying the coinsurance or copayment for the pelvic screening examination. There is no Part B deductible for the screening pelvic examination.

Screening Mammography Services

Medicare provides coverage for mammography screening, which is a radiologic procedure on an asymptomatic female for the early detection of breast cancer that serves as a baseline to which future screening or diagnostic mammograms may be compared, as follows:

- Annually (at least 11 full months have passed following the month in which the last covered screening mammography was performed) for all female beneficiaries age 40 or older; and
- One baseline mammogram for female beneficiaries between the ages of 35 and 39.

The following guidelines apply to screening mammography services:

- A physician's prescription or referral is not required for a screening mammography;
- Services must be provided at Food and Drug Administration (FDA) certified radiological facility; and
- The results must be interpreted by a qualified physician who is directly associated with the facility at which the mammogram was taken.

A female beneficiary may be at high risk for developing breast cancer if she:

- Has a personal history of breast cancer;
- Has a family history of breast cancer;
- Had her first baby after age 30; or
- Has never had a baby.

The beneficiary is responsible for paying the coinsurance or copayment for a screening mammography. There is no Part B deductible for a screening mammography.

Colorectal Cancer Screening

Medicare provides coverage for colorectal cancer screenings as follows:

- Fecal occult blood test (stool test), with written order from the beneficiary's attending physician
    - Once every 12 months (at least 11 months have passed following the month in which the last covered screening fecal occult blood test was performed) for all beneficiaries age 50 and older
    - An immunoassay-based fecal occult blood test may be performed as an alternative to the guaiac-based fecal occult blood test
- Flexible sigmoidoscopy, when ordered by a doctor of medicine or a doctor of osteopathy
    - For beneficiaries at high risk for developing colorectal cancer
        - Once every 4 years (at least 47 months have passed following the month in which the last covered screening flexible sigmoidoscopy was performed) for all beneficiaries age 50 and older
    - For beneficiaries not at high risk for developing colorectal cancer
        - Once every 4 years (at least 47 months have passed following the month in which the last covered screening flexible sigmoidoscopy was performed) for all beneficiaries age 50 and older
        - If the beneficiary has had a screening colonoscopy within the preceeding 10 years, the next screening flexible sigmoidoscopy will be covered only after at least 119 months have passed following the month in which the last covered colonoscopy was performed
- Screening colonoscopy, when performed by a doctor of medicine or a doctor of osteopathy
    - For beneficiaries at high risk for developing colorectal cancer
        - Once every 2 years for beneficiaries of any age
    - For beneficiaries not at high risk for developing colorectal cancer
        - Once every 10 years, but not within 47 months of a previous screening sigmoidoscopy

- Barium enema, as an alternative to a screening flexible sigmoidoscopy or screening colonoscopy
    - For beneficiaries of any age at high risk for developing colorectal cancer
        - Every 2 years (at least 23 months have passed following the month in which the last covered screening barium enema was performed)
    - For beneficiaries age 50 and older who are not at high risk for developing colorectal cancer
        - Once every 4 years (at least 47 months have passed following the month in which the last covered screening barium enema was performed)

The following guidelines apply to screening barium enemas:

- Must be ordered in writing after a determination that the procedure is appropriate;
- If the beneficiary cannot withstand a double contrast barium enema, the attending physician may order a single contrast barium enema.
- The attending physician must determine that the estimated screening potential for the barium enema is equal to or greater than the estimated screening potential for a screening flexible sigmoidoscopy or screening colonoscopy, as appropriate, for the same individual.

The high risk factors associated with colorectal cancer include any of the following:

- A close relative (sibling, parent, or child) who has had colorectal cancer or an adenomatous polyp;
- A family history of familial adenomatous polyposis;
- A family history of hereditary nonpolyposis colorectal cancer;
- A personal history of adenomatous polyps;
- A personal history of colorectal cancer; or
- A personal history of inflammatory bowel disease, including Crohn's Disease and ulcerative colitis.

The beneficiary pays no deductible, coinsurance, or copayment for fecal occult blood tests. The beneficiary is responsible for paying the coinsurance or copayment for flexible sigmoidoscopies, colonoscopies, and barium enemas after he or she has met the yearly Part B deductible. The beneficiary is responsible for 25 percent of the Medicare-approved amount after he or she has met the yearly Medicare Part B deductible for flexible sigmoidoscopies and colonoscopies that are performed in hospital outpatient departments.

Prostate Cancer Screening

The following guidelines apply to Medicare coverage of tests that detect prostate cancer:

- Prostate Specific Antigen (PSA) Blood Test
  - Once every 12 months (at least 11 months have passed following the month in which the last covered PSA test was performed) for male beneficiaries age 50 or older (coverage begins at least one day after attaining age 50) and
  - Must be ordered by a doctor of medicine, a doctor of osteopathy, CNM, PA, NP, or CNS who is
    - Authorized under State law to perform the examination
    - Fully knowledgeable about the beneficiary's medical condition
    - Responsible for using the results of any examination performed in the overall management of the beneficiary's medical problem
- Digital Rectal Examination (DRE)
  - Once every 12 months (at least 11 months have passed following the month in which the last covered DRE was performed) for male beneficiaries age 50 or older (coverage begins at least one day after attaining age 50) and
  - Must be performed by a doctor of medicine, a doctor of osteopathy, CNM, PA, NP, or CNS who is
    - Authorized under State law to perform the examination
    - Fully knowledgeable about the beneficiary's medical condition
    - Responsible for using the results of any examination performed in the overall management of the beneficiary's medical problem

High risk factors associated with prostate cancer include the following:

- A close relative (father, brother, or son) has a history of prostate cancer.

The beneficiary pays no deductible, coinsurance, or copayment for PSA blood tests. The beneficiary is responsible for paying the coinsurance or copayment after the yearly Part B deductible has been met for DREs.

Bone Mass Measurements

Effective for services furnished on or after July 1, 1998, bone mass measurements or bone density studies, including the physician's interpretation of the results of the procedure, are covered under Medicare every 2 years (at least 23 months have passed following the month in which the last covered bone density study was performed) when performed on a qualified individual at clinical

risk for osteoporosis. If medically necessary, Medicare may provide coverage for a beneficiary more frequently than every 2 years. A qualified individual meets at least one of the following medical indications:

- A woman who has been determined by the treating physician or qualified NPP to be estrogen-deficient and at clinical risk for osteoporosis, based on her medical history and other findings;
- An individual with vertebral abnormalities, as demonstrated by an x-ray to be indicative of osteoporosis, osteopenia (low bone mass), or vertebral fracture;
- An individual receiving (or expecting to receive) glucocorticoid (steroid) therapy equivalent to 7.5 mg of prednisone or greater per day for more than 3 months;
- An individual with known primary hyperparathyroidism; or
- An individual being monitored to assess the response to or efficacy of a FDA approved osteoporosis drug therapy.

In addition, all of the following coverage criteria must be met:

- Following an evaluation of the need for a bone mass measurement, the physician or qualified NPP treating the beneficiary must provide an order that includes a determination as to the medically appropriate measurement to be used for the individual;
- The service must be furnished by a qualified provider or supplier of such services under the appropriate level of supervision by a physician;
- The service must be reasonable and necessary for diagnosing, treating, or monitoring an individual as defined above; and
- The service must be a radiologic or radioisotopic procedure (or other procedure) that meets the following requirements:
    - Performed with a bone densitometer (other than dual photon absorptiometry or bone sonometer device [ultrasound]) approved or cleared for marketing by the FDA for bone density study purposes
    - Performed for the purpose of identifying bone mass, detecting bone loss, or determining bone quality and
    - Includes a physician's interpretation of the results of the procedure

The factors that place an individual at increased risk for developing osteoporosis include the following:

- Age 50 or older;
- Female gender;
- A family history of broken bones;
- A personal history of broken bones;
- Caucasian or Asian ethnicity;
- Small bone structure;
- Low body weight (less than 127 pounds);
- Frequent smoking or drinking; or
- Low-calcium diet.

Medical record documentation maintained by the treating physician must clearly indicate the medical necessity for ordering bone mass measurements. Documentation may be included in any of the following:

- Patient history and physical;
- Office notes;
- Test results with written interpretation; or
- X-ray/radiology with written interpretation.

The beneficiary is responsible for paying the coinsurance or copayment for bone mass measurements after he or she has met the yearly Part B deductible.

Glaucoma Screening

Glaucoma screenings are covered by Medicare annually (at least 11 months have passed following the month in which the last covered glaucoma screening examination was performed) when:

- The services are furnished by or under the direct supervision of an optometrist or ophthalmologist
- The optometrist or ophthalmologist is legally authorized to perform the services under State law; and
- The services are furnished in the office setting for eligible beneficiaries in one of the following high risk groups:
    - Individuals with diabetes mellitus
    - Individuals with a family history of glaucoma
    - African Americans age 50 or over or
    - Hispanic Americans age 65 or over (beginning on or after January 6, 2006)

A glaucoma screening includes:

- A dilated eye examination with an intraocular pressure measurement; and
- A direct ophthalmoscopy or slit-lamp biomicroscopic examination.

The beneficiary is responsible for paying the coinsurance or copayment for glaucoma screenings after he or she has met the yearly Part B deductible.

Influenza Vaccinations

Medicare provides coverage for one influenza vaccine and its administration per influenza season for all Medicare beneficiaries regardless of risk for the disease. Vaccination is recommended for individuals that fall within one or more of the following high risk or priority groups:

- Individuals age 65 or older;
- Children less than 3 years old;
- All women who will be pregnant during the flu season;
- Individuals of any age who have Acquired Immunodeficiency Syndrome (AIDS) and certain underlying health conditions such as heart or lung disease and transplant recipients;
- Residents of nursing homes and long-term care facilities;
- Children 2 - 18 years old on chronic aspirin therapy;
- Health care workers involved in direct patient care; and
- Out-of-home caregivers and household contacts of children less than 6 months of age or individuals in the high risk groups.

The beneficiary pays no deductible, coinsurance, or copayment for the influenza vaccine. If the beneficiary receives the influenza vaccination from a provider who does not accept assignment, the beneficiary pays the usual charge for administration of the vaccine.

Pneumococcal Polysaccharide Vaccinations

Medicare provides coverage for the pneumococcal polysaccharide vaccine (PPV) and its administration once in a lifetime for all Medicare beneficiaries. The following high priority target groups have been identified by the Centers for Disease Control:

- Individuals age 65 or older
- Individuals with a serious long-term health problem such as heart disease, sickle cell disease, alcoholism, leaks of cerebrospinal fluid, lung disease (not including asthma), diabetes, or liver cirrhosis

- Individuals with a lowered resistance to infection due to:
    - Hodgkin's disease
    - Multiple myeloma
    - Cancer treatment with x-rays or drugs
    - Treatment with long-term steroids
    - Bone marrow or organ transplant
    - Kidney failure
    - HIV/AIDS
    - Lymphoma, leukemia, or other cancers
    - Nephritic syndrome or
    - Damaged spleen or no spleen
- Alaskan Natives or individuals from certain Native American populations

Beneficiaries who are not sure of their vaccination status or are at high risk may be revaccinated if at least five years have passed since the last covered PPV. Revaccination is limited to the following beneficiaries with:

- Functional or anatomic asplenia (e.g., sickle cell disease or splenectomy);
- HIV infection;
- Leukemia;
- Lymphoma;
- Hodgkin's disease;
- Multiple myeloma;
- Generalized malignancy;
- Chronic renal failure;
- Nephrotic syndrome; or
- Other conditions associated with immunosuppression such as organ or bone marrow transplantation and immunosuppressive chemotherapy.

The beneficiary pays no deductible, coinsurance, or copayment for the vaccine. If the beneficiary receives the vaccination from a provider who does not accept assignment, the beneficiary pays the usual charge for administration of the vaccine.

Hepatitis B Vaccinations

Medicare provides coverage for Hepatitis B vaccinations for the following beneficiaries who are at high or intermediate risk for Hepatitis B Virus (HBV) infection when ordered by a doctor of medicine or a doctor of osteopathy:

- Individuals with End-Stage Renal Disease (ESRD);
- Individuals with hemophilia who received Factor VIII or IX concentrates;
- Clients of institutions for the mentally handicapped;
- Persons who live in the same household as a HBV carrier;
- Homosexual men;
- Illicit injectable drug users;
- Staff in institutions for the mentally handicapped;
- Health care professionals who have frequent contact with blood or blood-derived body fluids during routine work.

Individuals in the above risk group who have laboratory evidence positive for antibodies to HBV are not considered at high or intermediate risk of contracting HBV infection.

The beneficiary is responsible for paying the coinsurance or copayment for Hepatitis B vaccinations after he or she has met the yearly Part B deductible.

Smoking and Tobacco Use Cessation Counseling

For services furnished on or after March 22, 2005, Medicare Part B covers two new levels of counseling, intermediate and intensive, for smoking and tobacco use cessation counseling. This coverage is beyond the minimal smoking and tobacco use cessation counseling that is already considered to be covered at each E/M visit. Coverage is limited to beneficiaries who:

- Are competent and alert at the time services are furnished; and
- Use tobacco AND
    - Have a disease or adverse health effect found by the U.S. Surgeon General to be linked to tobacco use or
    - Are taking certain therapeutic agents whose metabolism or dosage is affected by tobacco use based on FDA-approved information

Two cessation attempts are covered each year. Each attempt may include a maximum of 4 intermediate or intensive sessions, up to 8 sessions in a 12-month period. The practitioner and patient have the flexibility to choose between intermediate or intensive cessation strategies for each attempt. These services are covered for outpatient and hospitalized beneficiaries who are smokers and qualify based on the above guidelines when furnished by qualified physicians or other Medicare-recognized practitioners (including providers).

The beneficiary is responsible for paying the coinsurance or copayment for smoking and tobacco use cessation counseling services after he or she has met the yearly Part B deductible.

To access the *Quick Reference Information: Medicare Preventive Services* job aid, visit *www.cms.hhs.gov/MLNProducts/downloads/qr_prevent_serv.pdf* on the CMS website.

Telehealth Services

Medicare beneficiaries are eligible for telehealth services only if they are presented from an originating site. Originating sites (location of the beneficiary) include the following:

- Physician or practitioner offices;
- Hospitals;
- CAHs;
- Rural Health Clinics; and
- FQHCs.

The originating site must be located in a rural HPSA or non-Metropolitan Statistical Area county. Entities that participate in a Federal Telemedicine demonstration project approved by (or receiving funding from) the Secretary of HHS as of December 31, 2000 qualify regardless of geographic location.

Practitioners at the distant site who may furnish and receive payment for telehealth services are:

- Physicians;
- NPs;
- PAs;
- CNMs;
- CNSs;
- CPs; and
- CSWs.

The current list of Medicare telehealth services include:

- Consultations (Current Procedural Terminology [CPT] codes 99241 – 99275®);
- Office or other outpatient visits (CPT codes 99201 – 99215);
- Individual psychotherapy (CPT codes 90804 – 90809);
- Pharmacologic management (CPT code 90862);
- Psychiatric diagnostic interview examination (CPT code 90801) (effective March 1, 2003); and
- ESRD-related services included in the monthly capitation payment (Healthcare Common Procedure Coding System [HCPCS] codes G0308, G0309, G0311, G0312, G0314, G0315, G0317, and G0318) (effective January 1, 2005).

Note: With regard to ESRD-related services, at least one face-to-face, "hands on" visit (not telehealth) must be furnished each month to examine the vascular access site by a physician, PA, NP, or CNS.

As a condition of payment, an interactive audio and video telecommunications system must be used that permits real-time communication between the physician or practitioner at the distant site and the beneficiary at the originating site. Asynchronous "store and forward" technology is permitted only in Federal telehealth demonstration programs conducted in Alaska or Hawaii.

Payment is made for the telehealth service furnished by the physician or practitioner at the distant site and a telehealth facility fee is made to the originating site. Claims for telehealth services should be submitted using the appropriate CPT or HCPCS code for the professional service and the telehealth modifier "GT" "via interactive audio and video telecommunications system" (e.g., 99243 GT). In the case of Federal telemedicine demonstration programs conducted in Alaska or Hawaii, submit the appropriate CPT code and telehealth modifier "GQ" "via asynchronous telecommunications system" (e.g., 99243 GQ). Claims for the facility fee should be submitted using HCPCS code Q3014: "Telehealth originating site facility fee."

To find additional information about telehealth services, visit *www.cms.hhs.gov/Telehealth* on the CMS website.

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Services That Medicare Does NOT Pay For

The services that Medicare does not pay for include the following:

- Excluded services:
  - Acupuncture
  - Care furnished in facilities located outside the U.S., except in limited cases
  - Cosmetic surgery, unless medically necessary to perform the procedure (e.g., a car accident disfigures facial structure and reconstruction is needed)
  - Custodial care (e.g., assistance with bathing and dressing) at the patient's home or in a nursing home
  - Most dental services
  - Hearing examinations
  - Orthopedic shoes
  - Routine eye care
  - Routine foot care, with the exception of certain patients with diabetes
  - Routine or annual physical examinations (with the exception of IPPEs)
  - Screening tests with no symptoms or documented conditions, with the exception of certain preventive screening tests (see the Preventive Services Section above for information about preventive screening tests)
  - Services related to excluded services and
  - Vaccinations, with certain exceptions (see the Injections, Drugs, and Biologicals and the Preventive Services Sections above for information about vaccinations)

- Services that are considered not medically necessary:
  - Services furnished in a hospital or SNF that, based on the patient's condition, could have been furnished elsewhere (e.g., the patient's home or a nursing home)
  - Hospital or SNF services that exceed Medicare length of stay limitations
  - E/M services that are in excess of those considered medically reasonable and necessary
  - Therapy or diagnostic procedures that are in excess of Medicare usage limits and
  - Services not warranted based on the diagnosis of the patient

- Services that have been denied as bundled or included in the basic allowance of another service:
    - Fragmented services included in the basic allowance of the initial service
    - Prolonged care (indirect)
    - Physician standby services
    - Case management services (e.g., telephone calls to and from the patient) and
    - Supplies included in the basic allowance of a procedure

- Claims that have been denied as "unprocessable"

To find additional information about payment policies, see the Medicare Benefit Policy Manual (Pub. 100-2) at *www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage* on the CMS website.

CHAPTER 5

EVALUATION AND MANAGEMENT DOCUMENTATION

The following evaluation and management (E/M) documentation topics are discussed in this chapter:

- Guidelines for residents and teaching physicians; and
- Evaluation and management background.

Also included are the following reference materials:

- Reference I - *1995 Documentation Guidelines for Evaluation and Management Services*; and
- Reference II - *1997 Documentation Guidelines for Evaluation and Management Services*.

Guidelines for Residents and Teaching Physicians

Both residents and teaching physicians may document physician services in the patient's medical record. The documentation must be dated and contain a legible signature or identity and may be:

- Dictated and transcribed;
- Typed;
- Hand-written; or
- Computer-generated.

The attending physician who bills Medicare for E/M services in the teaching setting must, at a minimum, personally document:

- His or her participation in the management of the patient; and
- That he or she performed the service or was physically present during the critical or key portion(s) of the service performed by the resident (the resident's certification that the attending physician was present is not sufficient).

Students may also document services in the patient's medical record. The teaching physician may refer only to a student's E/M documentation that is related to a review of systems (ROS) and/or past, family, and/or social history (PFSH). If the medical student documents E/M services, the teaching physician must verify and repeat documentation of the physical examination and medical decision making activities of the service.

The following guidelines apply to the documentation required for the three major categories of E/M services:

Initial Hospital Care, Emergency Department Visits, Office Visits for New Patients, Office Consultations, and Hospital Consultations

For initial hospital care, department visits, office visits for new patients, office consultations, and hospital consultations, the teaching physician must enter a personal notation that demonstrates the appropriate level of service that the patient requires and documents his or her participation in the following three key components:

- History;
- Examination; and
- Medical decision making.

If the teaching physician repeats key elements of the service components that the resident previously obtained and documented, his or her note may be brief, summarize comments that relate to the resident's entry, and confirm or revise the following key elements:

- Relevant history of present illness (HPI) and prior diagnostic tests;
- Major finding(s) of the physical examination;
- Assessment, clinical impression, or diagnosis; and
- Plan of care.

Subsequent Hospital Care and Office Visits for Established Patients

For subsequent hospital care and office visits for established patients, the teaching physician must enter a personal notation that highlights two of the three following key components:

- History;
- Physical examination; and
- Medical decision making.

For follow-up visits for established patients, the initial hospital care, emergency department visits, office visits for new patients, office consultations, and hospital consultations guidelines described above must be followed.

Exception for Evaluation and Management Services Furnished in Certain Primary Care Centers

Medicare may grant a primary care exception within a Graduate Medical Education (GME) Program in which the teaching physician is paid for certain E/M services the resident performs when the teaching physician is not present. The primary care exception applies to the following lower and mid-level E/M services and the initial preventive physical examination (IPPE) (also known as the "Welcome to Medicare Physical"):

New Patient	Established Patient
CPT Code 99201®	CPT Code 99211
CPT Code 99202	CPT Code 99212
CPT Code 99203	CPT Code 99213

Effective January 1, 2005, the following code for the IPPE is included under the primary exception:

- Healthcare Common Procedure Coding System code G3044: Initial Preventive Physical Examination: face-to-face visit, services limited to new beneficiary during the first six months of Medicare enrollment.

The range of services furnished by residents include the following:

- Acute care for undifferentiated problems or chronic care for ongoing conditions including chronic mental illness;
- Coordination of care furnished by other providers; and
- Comprehensive care not limited by organ system or diagnosis.

The types of residency programs most likely to qualify for the primary care exception include family practice, general internal medicine, geriatric medicine, pediatrics, and obstetrics/gynecology. Certain GME programs in psychiatry may qualify in special situations, such as when the program furnishes comprehensive care for chronically mentally ill patients.

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A center must attest in writing that all of the following conditions are met for a particular residency program:

- The services must be furnished in a center located in the outpatient department of a hospital or another ambulatory care entity in which the time spent by residents in patient care activities is included in determining direct GME payments to a teaching hospital.
- Any resident furnishing the service without the presence of a teaching physician must have completed more than six months of an approved residency program.
- The teaching physician in whose name the payment is sought must not supervise more than four residents at any given time and must direct the care from such proximity as to constitute immediate availability. The teaching physician must:
    - Have no other responsibilities, including the supervision of other personnel, at the time of the service for which payment is sought
    - Assume management responsibility for those patients seen by the residents
    - Ensure that the services furnished are appropriate
    - Review the patient's medical history, physical examination, diagnosis, and record of tests and therapies with each resident during or immediately after each visit and
    - Document the extent of his or her own participation in the review and direction of the services furnished to each patient
- The patients seen must be an identifiable group of individuals who consider the center to be the continuing source of their health care and in which services are furnished by residents under the medical direction of teaching physicians. The residents must generally follow the same group of patients throughout the course of their residency program, but there is no requirement that teaching physicians remain the same over any period of time.

Evaluation and Management Background

Medicare pays physicians based on diagnostic and procedure codes that are derived from medical documentation. E/M documentation is the pathway that translates a physician's patient care work into the claims and reimbursement mechanism. This pathway's accuracy is critical in:

- Ensuring that physicians are paid correctly for their work;
- Supporting the correct E/M code level; and
- Providing the validation required for medical review.

E/M includes some or all of the following elements:

- Documenting history. Each type of history includes some or all of the following elements:
  - Chief complaint
    - A concise statement that describes the symptom, problem, condition, diagnosis, or reason for the patient encounter
    - Usually stated in the patient's own words
  - HPI
    - Brief, which includes 1 to 3 elements
    - Extended, which includes at least 4 elements OR the status of at least 3 chronic or inactive conditions
  - Conducting a ROS, which is an inventory of body systems obtained through a series of questions that seek to identify signs and symptoms that the patient may be experiencing or has experienced. The three types of ROS are:
    - Problem pertinent, which inquires about the system directly related to the problem identified in the HPI
    - Extended, which inquires about the system directly related to the problem(s) identified in the HPI and a limited number of additional systems (2 – 9)
    - Complete, which inquires about the system(s) directly related to the problem(s) identified in the HPI plus all additional body systems (minimum of 10) and
  - Examining relevant PFSH which consists of a review of the following three areas:
    - Experiences with illnesses, operations, injuries, and treatments
    - Medical events, diseases, and hereditary conditions that may place the patient at risk
    - Social history that includes age appropriate review of past and current activities

    The two types of PFSH are:
    - Pertinent, which is a review of the history areas directly related to the problem(s) identified in the HPI
    - Complete, which is a review of 2 or all 3 of the history areas, depending upon the category of E/M service

- Performing a physical examination. The extent of the examination performed is based upon:
  - Clinical judgment
  - The patient's history and
  - The nature of the presenting problem(s)

The two types of examinations are:

- General multi-system
  - Involves the examination of 1 or more organ systems or body areas
  - Each body area or organ system contains 2 or more examination elements and
- Single organ system
  - Involves a more extensive examination of a specific organ system

Both general multi-system and single organ system examinations can be one of the following types:

- Problem focused
  - A limited examination of the affected body area or organ system
- Expanded problem focused
  - A limited examination of the affected body area or organ system and any other symptomatic or related body area(s) or organ system(s)
- Detailed
  - An extended examination of the affected body areas(s) or organ system(s) and any other symptomatic or related body area(s) or organ system(s) or
- Comprehensive
  - A general multi-system examination OR complete examination of a single organ system and other symptomatic or related body area(s) or organ system(s)

- Considering all identified diagnostic and therapeutic factors when making decisions about the patient's illness and treatment. Medical decision making can be one of the following types:
  - Straightforward
  - Low complexity
  - Moderate complexity or
  - High complexity

The complexity of medical decision making is determined by considering the following factors:

- The number of possible diagnoses and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed and
- The risk of significant complications, morbidity and/or mortality as well as comorbidities associated with the patient's presenting problem(s), the diagnostic procedure(s), and/or the possible management options

- Documenting an encounter dominated by counseling and/or coordination of care (more than 50 percent of the total time) in a face-to-face physician/patient encounter:
  - Time is the key or controlling factor to qualify for a particular level of E/M service and
  - Includes time spent with the patient and/or the patient and his or her family in the office or other outpatient setting, on the floor of a hospital, or a nursing facility

Providers may use either the *1995 Documentation Guidelines for Evaluation and Management Services* or the *1997 Documentation Guidelines for Evaluation and Management Services* (see Reference I and Reference II below). Medicare Contractors must conduct reviews using both the 1995 and the 1997 guidelines and apply the guidelines that are most advantageous to the provider.

To find additional information about E/M documentation, visit *www.cms.hhs.gov/MLNEdWebGuide/25_EMDOC.asp#TopOfPage* and see the Medicare Claims Processing Manual (Pub. 100-4) at *www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage* on the CMS website.

REFERENCE I

1995 DOCUMENTATION GUIDELINES FOR EVALUATION & MANAGEMENT SERVICES

I. INTRODUCTION

WHAT IS DOCUMENTATION AND WHY IS IT IMPORTANT?

Medical record documentation is required to record pertinent facts, findings, and observations about an individual's health history including past and present illnesses, examinations, tests, treatments, and outcomes. The medical record chronologically documents the care of the patient and is an important element contributing to high quality care. The medical record facilitates:

- the ability of the physician and other healthcare professionals to evaluate and plan the patient's immediate treatment, and to monitor his/her healthcare over time;
- communication and continuity of care among physicians and other healthcare professionals involved in the patient's care;
- accurate and timely claims review and payment;
- appropriate utilization review and quality of care evaluations; and
- collection of data that may be useful for research and education.

An appropriately documented medical record can reduce many of the "hassles" associated with claims processing and may serve as a legal document to verify the care provided, if necessary.

WHAT DO PAYERS WANT AND WHY?

Because payers have a contractual obligation to enrollees, they may require reasonable documentation that services are consistent with the insurance coverage provided. They may request information to validate:

- the site of service;

- the medical necessity and appropriateness of the diagnostic and/or therapeutic services provided; and/or

- that services provided have been accurately reported.

II. GENERAL PRINCIPLES OF MEDICAL RECORD DOCUMENTATION

The principles of documentation listed below are applicable to all types of medical and surgical services in all settings. For Evaluation and Management (E/M) services, the nature and amount of physician work and documentation varies by type of service, place of service and the patient's status. The general principles listed below may be modified to account for these variable circumstances in providing E/M services.

1. The medical record should be complete and legible.

2. The documentation of each patient encounter should include:

    - reason for the encounter and relevant history, physical examination findings, and prior diagnostic test results;

    - assessment, clinical impression, or diagnosis;

    - plan for care; and

    - date and legible identity of the observer.

3. If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred.

4. Past and present diagnoses should be accessible to the treating and/or consulting physician.

5. Appropriate health risk factors should be identified.

6. The patient's progress, response to and changes in treatment, and revision of diagnosis should be documented.

7. The CPT and ICD-9-CM codes reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record.

2

II. DOCUMENTATION OF E/M SERVICES

This publication provides definitions and documentation guidelines for the three ***key*** components of E/M services and for visits which consist predominately of counseling or coordination of care. The three key components--history, examination, and medical decision making--appear in the descriptors for office and other outpatient services, hospital observation services, hospital inpatient services, consultations, emergency department services, nursing facility services, domiciliary care services, and home services. While some of the text of CPT has been repeated in this publication, the reader should refer to CPT for the complete descriptors for E/M services and instructions for selecting a level of service. **Documentation guidelines are identified by the symbol • DG.**

The descriptors for the levels of E/M services recognize seven components which are used in defining the levels of E/M services. These components are:

- history;
- examination;
- medical decision making;
- counseling;
- coordination of care;
- nature of presenting problem; and
- time.

The first three of these components (i.e., history, examination and medical decision making) are the ***key*** components in selecting the level of E/M services. An exception to this rule is the case of visits which consist predominantly of counseling or coordination of care; for these services time is the key or controlling factor to qualify for a particular level of E/M service.

For certain groups of patients, the recorded information may vary slightly from that described here. Specifically, the medical records of infants, children, adolescents and pregnant women may have additional or modified information recorded in each history and examination area.

3

As an example, newborn records may include under history of the present illness (HPI) the details of mother's pregnancy and the infant's status at birth; social history will focus on family structure; family history will focus on congenital anomalies and hereditary disorders in the family. In addition, information on growth and development and/or nutrition will be recorded. Although not specifically defined in these documentation guidelines, these patient group variations on history and examination are appropriate.

A. DOCUMENTATION OF HISTORY

The levels of E/M services are based on four types of history (Problem Focused, Expanded Problem Focused, Detailed, and Comprehensive). Each type of history includes some or all of the following elements:

- Chief complaint (CC);
- History of present illness (HPI);
- Review of systems (ROS); and
- Past, family and/or social history (PFSH).

The extent of history of present illness, review of systems, and past, family and/or social history that is obtained and documented is dependent upon clinical judgment and the nature of the presenting problem(s).

The chart below shows the progression of the elements required for each type of history. To qualify for a given type of history, **all three elements in the table must be met.** (A chief complaint is indicated at all levels.)

History of Present Illness (HPI)	Review of Systems (ROS)	Past, Family, and/or Social History (PFSH)	Type of History
Brief	N/A	N/A	***Problem Focused***
Brief	Problem Pertinent	N/A	***Expanded Problem Focused***
Extended	Extended	Pertinent	***Detailed***
Extended	Complete	Complete	***Comprehensive***

4

- *DG: The CC, ROS and PFSH may be listed as separate elements of history, or they may be included in the description of the history of the present illness.*

- *DG: A ROS and/or a PFSH obtained during an earlier encounter does not need to be re-recorded if there is evidence that the physician reviewed and updated the previous information. This may occur when a physician updates his/her own record or in an institutional setting or group practice where many physicians use a common record. The review and update may be documented by:*

    - *describing any new ROS and/or PFSH information or noting there has been no change in the information; and*

    - *noting the date and location of the earlier ROS and/or PFSH.*

- *DG: The ROS and/or PFSH may be recorded by ancillary staff or on a form completed by the patient. To document that the physician reviewed the information, there must be a notation supplementing or confirming the information recorded by others.*

- *DG: If the physician is unable to obtain a history from the patient or other source, the record should describe the patient's condition or other circumstance which precludes obtaining a history.*

Definitions and specific documentation guidelines for each of the elements of history are listed below.

CHIEF COMPLAINT (CC)

The CC is a concise statement describing the symptom, problem, condition, diagnosis, physician recommended return, or other factor that is the reason for the encounter.

- *DG: The medical record should clearly reflect the chief complaint.*

5

HISTORY OF PRESENT ILLNESS (HPI)

The HPI is a chronological description of the development of the patient's present illness from the first sign and/or symptom or from the previous encounter to the present. It includes the following elements:

- location;
- quality;
- severity;
- duration;
- timing;
- context;
- modifying factors; and
- associated signs and symptoms.

Brief and ***extended*** HPIs are distinguished by the amount of detail needed to accurately characterize the clinical problem(s).

A ***brief*** HPI consists of one to three elements of the HPI.

- *DG: The medical record should describe one to three elements of the present illness (HPI).*

An ***extended*** HPI consists of four or more elements of the HPI.

- *DG: The medical record should describe four or more elements of the present illness (HPI) or associated comorbidities.*

REVIEW OF SYSTEMS (ROS)

A ROS is an inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms which the patient may be experiencing or has experienced.

For purposes of ROS, the following systems are recognized:

- Constitutional symptoms (e.g., fever, weight loss)
- Eyes
- Ears, Nose, Mouth, Throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Integumentary (skin and/or breast)
- Neurological
- Psychiatric
- Endocrine
- Hematologic/Lymphatic
- Allergic/Immunologic

A ***problem pertinent*** ROS inquires about the system directly related to the problem(s) identified in the HPI.

- *DG: The patient's positive responses and pertinent negatives for the system related to the problem should be documented.*

An ***extended*** ROS inquires about the system directly related to the problem(s) identified in the HPI and a limited number of additional systems.

- *DG: The patient's positive responses and pertinent negatives for two to nine systems should be documented.*

7

A ***complete*** ROS inquires about the system(s) directly related to the problem(s) identified in the HPI plus all additional body systems.

- *DG: At least ten organ systems must be reviewed. Those systems with positive or pertinent negative responses must be individually documented. For the remaining systems, a notation indicating all other systems are negative is permissible. In the absence of such a notation, at least ten systems must be individually documented.*

PAST, FAMILY, AND/OR SOCIAL HISTORY (PFSH)

The PFSH consists of a review of three areas:

- past history (the patient's past experiences with illnesses, operations, injuries and treatments);
- family history (a review of medical events in the patient's family, including diseases which may be hereditary or place the patient at risk); and
- social history (an age appropriate review of past and current activities).

For the categories of subsequent hospital care, follow-up inpatient consultations and subsequent nursing facility care, CPT requires only an "interval" history. It is not necessary to record information about the PFSH.

A ***pertinent*** PFSH is a review of the history area(s) directly related to the problem(s) identified in the HPI.

- *DG: At least one specific item from any of the three history areas must be documented for a pertinent PFSH.*

A ***complete*** PFSH is of a review of two or all three of the PFSH history areas, depending on the category of the E/M service. A review of all three history areas is required for services that by their nature include a comprehensive assessment or reassessment of the patient. A review of two of the three history areas is sufficient for other services.

- *DG: At least one specific item from two of the three history areas must be documented for a complete PFSH for the following categories of E/M services: office or other outpatient services, established patient; emergency department; subsequent nursing facility care; domiciliary care, established patient; and home care, established patient.*

- *DG: At least one specific item from each of the three history areas must be documented for a complete PFSH for the following categories of E/M services: office or other outpatient services, new patient; hospital observation services; hospital inpatient services, initial care; consultations; comprehensive nursing facility assessments; domiciliary care, new patient; and homecare, new patient.*

B. DOCUMENTATION OF EXAMINATION

The levels of E/M services are based on four types of examination that are defined as follows:

- ***Problem Focused*** -- a limited examination of the affected body area or organ system.

- ***Expanded Problem Focused*** -- a limited examination of the affected body area or organ system and other symptomatic or related organ system(s).

- ***Detailed*** -- an extended examination of the affected body area(s) and other symptomatic or related organ system(s).

- ***Comprehensive*** -- a general multi-system examination or complete examination of a single organ system.

For purposes of examination, the following ***body areas*** are recognized:

- Head, including the face
- Neck
- Chest, including breasts and axillae
- Abdomen
- Genitalia, groin, buttocks
- Back, including spine
- Each extremity

9

For purposes of examination, the following ***organ systems*** are recognized:

- Constitutional (e.g., vital signs, general appearance)
- Eyes
- Ears, nose, mouth, and throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Skin
- Neurologic
- Psychiatric
- Hematologic/lymphatic/immunologic

The extent of examinations performed and documented is dependent upon clinical judgment and the nature of the presenting problem(s). They range from limited examinations of single body areas to general multi-system or complete single organ system examinations.

- *DG: Specific abnormal and relevant negative findings of the examination of the affected or symptomatic body area(s) or organ system(s) should be documented. A notation of "abnormal" without elaboration is insufficient.*
- *DG: Abnormal or unexpected findings of the examination of the unaffected or asymptomatic body area(s) or organ system(s) should be described.*
- *DG: A brief statement or notation indicating "negative" or "normal" is sufficient to document normal findings related to unaffected area(s) or asymptomatic organ system(s).*

10

C. DOCUMENTATION OF THE COMPLEXITY OF MEDICAL DECISION MAKING

The levels of E/M services recognize four types of medical decision making (straight-forward, low complexity, moderate complexity, and high complexity). Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option as measured by:

- the number of possible diagnoses and/or the number of management options that must be considered;
- the amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed; and
- the risk of significant complications, morbidity, and/or mortality, as well as comorbidities associated with the patient's presenting problem(s), the diagnostic procedure(s) and/or the possible management options.

The chart below shows the progression of the elements required for each level of medical decision making. To qualify for a given type of decision making, **two of the three elements in the table must be either met or exceeded.**

Number of diagnoses or management options	Amount and/or complexity of data to be reviewed	Risk of complications and/or morbidity or mortality	Type of decision making
Minimal	Minimal or None	Minimal	***Straightforward***
Limited	Limited	Low	***Low Complexity***
Multiple	Moderate	Moderate	***Moderate Complexity***
Extensive	Extensive	High	***High Complexity***

Each of the elements of medical decision making is described on the following page.

NUMBER OF DIAGNOSES OR MANAGEMENT OPTIONS

The number of possible diagnoses and/or the number of management options that must be considered is based on the number and types of problems addressed during the encounter, the complexity of establishing a diagnosis and the management decisions that are made by the physician.
11

Generally, decision making with respect to a diagnosed problem is easier than that for an identified but undiagnosed problem. The number and type of diagnostic tests employed may be an indicator of the number of possible diagnoses. Problems which are improving or resolving are less complex than those which are worsening or failing to change as expected. The need to seek advice from others is another indicator of complexity of diagnostic or management problems.

- *DG: For each encounter, an assessment, clinical impression, or diagnosis should be documented. It may be explicitly stated or implied in documented decisions regarding management plans and/or further evaluation.*

    - *For a presenting problem with an established diagnosis the record should reflect whether the problem is: a) improved, well controlled, resolving or resolved; or, b) inadequately controlled, worsening, or failing to change as expected.*

    - *For a presenting problem without an established diagnosis, the assessment or clinical impression may be stated in the form of a differential diagnoses or as "possible," "probable," or "rule out" (R/O) diagnoses.*

- *DG: The initiation of, or changes in, treatment should be documented. Treatment includes a wide range of management options including patient instructions, nursing instructions, therapies, and medications.*

- *DG: If referrals are made, consultations requested or advice sought, the record should indicate to whom or where the referral or consultation is made or from whom the advice is requested.*

AMOUNT AND/OR COMPLEXITY OF DATA TO BE REVIEWED

The amount and complexity of data to be reviewed is based on the types of diagnostic testing ordered or reviewed. A decision to obtain and review old medical records and/or obtain history from sources other than the patient increases the amount and complexity of data to be reviewed.

Discussion of contradictory or unexpected test results with the physician who performed or interpreted the test is an indication of the complexity of data being

reviewed. On occasion the physician who ordered a test may personally review the image, tracing or specimen to supplement information from the physician who prepared the test report or interpretation; this is another indication of the complexity of data being reviewed.

- *DG: If a diagnostic service (test or procedure) is ordered, planned, scheduled, or performed at the time of the E/M encounter, the type of service, eg, lab or x-ray, should be documented.*

- *DG: The review of lab, radiology and/or other diagnostic tests should be documented. An entry in a progress note such as "WBC elevated" or "chest x-ray unremarkable" is acceptable. Alternatively, the review may be documented by initialing and dating the report containing the test results.*

- *DG: A decision to obtain old records or decision to obtain additional history from the family, caretaker or other source to supplement that obtained from the patient should be documented.*

- *DG: Relevant finding from the review of old records, and/or the receipt of additional history from the family, caretaker or other source should be documented. If there is no relevant information beyond that already obtained, that fact should be documented. A notation of "Old records reviewed" or "additional history obtained from family" without elaboration is insufficient.*

- *DG: The results of discussion of laboratory, radiology or other diagnostic tests with the physician who performed or interpreted the study should be documented.*

- *DG: The direct visualization and independent interpretation of an image, tracing, or specimen previously or subsequently interpreted by another physician should be documented.*

13

RISK OF SIGNIFICANT COMPLICATIONS, MORBIDITY, AND/OR MORTALITY

The risk of significant complications, morbidity, and/or mortality is based on the risks associated with the presenting problem(s), the diagnostic procedure(s), and the possible management options.

- *DG: Comorbidities/underlying diseases or other factors that increase the complexity of medical decision making by increasing the risk of complications, morbidity, and/or mortality should be documented.*

- *DG: If a surgical or invasive diagnostic procedure is ordered, planned, or scheduled at the time of the E/M encounter, the type of procedure eg, laparoscopy, should be documented.*

- *DG: If a surgical or invasive diagnostic procedure is performed at the time of the E/M encounter, the specific procedure should be documented.*

- *DG: The referral for or decision to perform a surgical or invasive diagnostic procedure on an urgent basis should be documented or implied.*

The following table may be used to help determine whether the risk of significant complications, morbidity, and/or mortality is **minimal**, **low**, **moderate**, or **high**. Because the determination of risk is complex and not readily quantifiable, the table includes common clinical examples rather than absolute measures of risk. The assessment of risk of the presenting problem(s) is based on the risk related to the disease process anticipated between the present encounter and the next one. The assessment of risk of selecting diagnostic procedures and management options is based on the risk during and immediately following any procedures or treatment. The highest level of risk in any one category (presenting problem(s), diagnostic procedure(s), or management options) determines the overall risk.

Table of Risk

Level of Risk	Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Management Options Selected
Minimal	One self-limited or minor problem, eg, cold, insect bite, tinea corporis	Laboratory tests requiring venipuncture Chest x-rays EKG/EEG Urinalysis Ultrasound, eg, echocardiography KOH prep	Rest Gargles Elastic bandages Superficial dressings
Low	Two or more self-limited or minor problems One stable chronic illness, eg, well controlled hypertension, non-insulin dependent diabetes, cataract, BPH Acute uncomplicated illness or injury, eg, cystitis, allergic rhinitis, simple sprain	Physiologic tests not under stress, eg, pulmonary function tests Non-cardiovascular imaging studies with contrast, eg, barium enema Superficial needle biopsies Clinical laboratory tests requiring arterial puncture Skin biopsies	Over-the-counter drugs Minor surgery with no identified risk factors Physical therapy Occupational therapy IV fluids without additives
Moderate	One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment Two or more stable chronic illnesses Undiagnosed new problem with uncertain prognosis, eg, lump in breast Acute illness with systemic symptoms, eg, pyelonephritis, pneumonitis, colitis Acute complicated injury, eg, head injury with brief loss of consciousness	Physiologic tests under stress, eg, cardiac stress test, fetal contraction stress test Diagnostic endoscopies with no identified risk factors Deep needle or incisional biopsy Cardiovascular imaging studies with contrast and no identified risk factors, eg, arteriogram, cardiac catheterization Obtain fluid from body cavity, eg lumbar puncture, thoracentesis, culdocentesis	Minor surgery with identified risk factors Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors Prescription drug management Therapeutic nuclear medicine IV fluids with additives Closed treatment of fracture or dislocation without manipulation
High	One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment Acute or chronic illnesses or injuries that pose a threat to life or bodily function, eg, multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure An abrupt change in neurologic status, eg, seizure, TIA, weakness, sensory loss	Cardiovascular imaging studies with contrast with identified risk factors Cardiac electrophysiological tests Diagnostic Endoscopies with identified risk factors Discography	Elective major surgery (open, percutaneous or endoscopic) with identified risk factors Emergency major surgery (open, percutaneous or endoscopic) Parenteral controlled substances Drug therapy requiring intensive monitoring for toxicity Decision not to resuscitate or to de-escalate care because of poor prognosis

D. DOCUMENTATION OF AN ENCOUNTER DOMINATED BY COUNSELING OR COORDINATION OF CARE

In the case where counseling and/or coordination of care dominates (more than 50%) of the physician/patient and/or family encounter (face-to-face time in the office or other outpatient setting or floor/unit time in the hospital or nursing facility), time is considered the key or controlling factor to qualify for a particular level of E/M services.

- *DG: If the physician elects to report the level of service based on counseling and/or coordination of care, the total length of time of the encounter (face-to-face or floor time, as appropriate) should be documented and the record should describe the counseling and/or activities to coordinate care.*

16

REFERENCE II

1997 DOCUMENTATION GUIDELINES FOR EVALUATION & MANAGEMENT SERVICES

TABLE OF CONTENTS

Introduction 2

What Is Documentation and Why Is it Important? 2

What Do Payers Want and Why? 2

General Principles of Medical Record Documentation 3

Documentation of E/M Services....4

Documentation of History 5

Chief Complaint (CC) 6

History of Present Illness (HPI) 7

Review of Systems (ROS) 8

Past, Family and/or Social History (PFSH) 9

Documentation of Examination 10

General Multi-System Examinations 11

Single Organ System Examinations 12

Content and Documentation Requirements 13

General Multi-System Examination 13
- Cardiovascular Examination 18
- Ear, Nose and Throat Examination 20
- Eye Examination 23
- Genitourinary Examination 26
- Hematologic/Lymphatic/Immunologic Examination 29
- Musculoskeletal Examination 32
- Neurological Examination 35

Psychiatric Examination 38
Respiratory Examination 39
Skin Examination 42

Documentation of the Complexity of Medical Decision Making 43

Number of Diagnoses or Management Options 44

Amount and/or Complexity of Data to Be Reviewed 45

Risk of Significant Complications, Morbidity, and/or Mortality 46

Table of Risk 47

Documentation of an Encounter Dominated by Counseling or Coordination of Care 48

I. INTRODUCTION

WHAT IS DOCUMENTATION AND WHY IS IT IMPORTANT?

Medical record documentation is required to record pertinent facts, findings, and observations about an individual's health history including past and present illnesses, examinations, tests, treatments, and outcomes. The medical record chronologically documents the care of the patient and is an important element contributing to high quality care. The medical record facilitates:

- **the ability of the physician and other healthcare professionals to evaluate and plan the patient's immediate treatment, and to monitor his/her healthcare over time.**
- **communication and continuity of care among physicians and other healthcare professionals involved in the patient's care;**
- **accurate and timely claims review and payment;**
- **appropriate utilization review and quality of care evaluations; and**
- **collection of data that may be useful for research and education.**

An appropriately documented medical record can reduce many of the hassles associated with claims processing and may serve as a legal document to verify the care provided, if necessary.

WHAT DO PAYERS WANT AND WHY?

Because payers have a contractual obligation to enrollees, they may require reasonable documentation that services are consistent with the insurance coverage provided. They may request information to validate:

- **the site of service;**
- **the medical necessity and appropriateness of the diagnostic and/or therapeutic services provided; and/or**
- **that services provided have been accurately reported.**

II. GENERAL PRINCIPLES OF MEDICAL RECORD DOCUMENTATION

The principles of documentation listed below are applicable to all types of medical and surgical services in all settings. For Evaluation and Management (E/M) services, the nature and amount of physician work and documentation varies by type of service, place of service and the patient's status. The general principles listed below may be modified to account for these variable circumstances in providing E/M services.

1. **The medical record should be complete and legible.**

2. **The documentation of each patient encounter should include:**

   - **reason for encounter and relevant history, physical examination findings, and prior diagnostic test results;**

   - **assessment, clinical impression, or diagnosis;**

   - **plan for care; and**

   - **date and legible identity of the observer.**

3. **If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred.**

4. **Past and present diagnoses should be accessible to the treating and/or consulting physician.**

5. **Appropriate health risk factors should be identified.**

6. **The patient's progress, response to and changes in treatment, and revision of diagnosis should be documented.**

7. **The CPT and ICD-9-CM codes reported on the health insurance claim form should be supported by the documentation in the medical record.**

III. DOCUMENTATION OF E/M SERVICES

This publication provides definitions and documentation guidelines for the three key components of E/M services and for visits which consist predominately of counseling or coordination of care. The three *key* components--history, examination, and medical decision making--appear in the descriptors for office and other outpatient services, hospital observation services, hospital inpatient services, consultations, emergency department services, nursing facility services, domiciliary care services, and home services. While some of the text of CPT has been repeated in this publication, the reader should refer to CPT for the complete descriptors for E/M services and instructions for selecting a level of service. Documentation guidelines are identified by the symbol • DG.

The descriptors for the levels of E/M services recognize seven components which are used in defining the levels of E/M services. These components are:

- **history;**
- **examination;**
- **medical decision making;**
- **counseling;**
- **coordination of care;**
- **nature of presenting problem; and**
- **time.**

The first three of these components (i.e., history, examination and medical decision making) are the key components in selecting the level of E/M services. In the case of visits which consist predominantly of counseling or coordination of care, time is the key or controlling factor to qualify for a particular level of E/M service.

Because the level of E/M service is dependent on two or three key components, performance and documentation of one component (eg, examination) at the highest level does not necessarily mean that the encounter in its entirety qualifies for the highest level of E/M service.

These Documentation Guidelines for E/M services reflect the needs of the typical adult population. For certain groups of patients, the recorded information may vary slightly from that described here. Specifically, the medical records of infants, children, adolescents and pregnant women may

have additional or modified information recorded in each history and examination area.

As an example, newborn records may include under history of the present illness (HPI) the details of mother's pregnancy and the infant's status at birth; social history will focus on family structure; family history will focus on congenital anomalies and hereditary disorders in the family. In addition, the content of a pediatric examination will vary with the age and development of the child. Although not specifically defined in these documentation guidelines, these patient group variations on history and examination are appropriate.

A. DOCUMENTATION OF HISTORY

The levels of E/M services are based on four levels of history (Problem Focused, Expanded Problem Focused, Detailed, and Comprehensive). Each type of history includes some or all of the following elements:

- Chief complaint (CC)
- History of present illness (HPI)
- Review of systems (ROS) and
- Past, family, and/or social history (PFSH).

The extent of the history of present illness, review of systems, and past, family and/or social history that is obtained and documented is dependent upon clinical judgment and the nature of the presenting problem(s).

The chart below shows the progression of the elements required for each type of history. To qualify for a given type of history all three elements in the table must be met. (A chief complaint is indicated at all levels.)

History of Present Illness (HPI)	Review of Systems (ROS)	Past, Family, and/or Social History (PFSH)	Type of History
Brief	N/A	N/A	*Problem Focused*
Brief Problem	Problem Pertinent	N/A	*Focused Expanded Problem*
Extended	Extended	Pertinent	*Detailed*
Extended	Complete	Complete	*Comprehensive*

5

- *DG: The CC, ROS and PFSH may be listed as separate elements of history, or they may be included in the description of the history of the present illness.*

- *DG: A ROS and/or a PFSH obtained during an earlier encounter does not need to be re-recorded if there is evidence that the physician reviewed and updated the previous information. This may occur when a physician updates his/her own record or in an institutional setting or group practice where many physicians use a common record. The review and update may be documented by:*

    - *describing any new ROS and/or PFSH information or noting there has been no change in the information; and*

    - *noting the date and location of the earlier ROS and/or PFSH.*

- *DG: The ROS and/or PFSH may be recorded by ancillary staff or on a form completed by the patient. To document that the physician reviewed the information, there must be a notation supplementing or confirming the information recorded by others.*

- *DG: If the physician is unable to obtain a history from the patient or other source, the record should describe the patient's condition or other circumstance that precludes obtaining a history.*

Definitions and specific documentation guidelines for each of the elements of history are listed below.

CHIEF COMPLAINT (CC)

The CC is a concise statement describing the symptom, problem, condition, diagnosis, physician recommended return, or other factor that is the reason for the encounter, usually stated in the patient's own words.

- *DG: The medical record should clearly reflect the chief complaint.*

HISTORY OF PRESENT ILLNESS (HPI)

The HPI is a chronological description of the development of the patient's present illness from the first sign and/or symptom or from the previous encounter to the present. It includes the following elements:

- **location ,**
- **quality ,**
- **severity,**
- **duration,**
- **timing,**
- **context ,**
- **modifying factors, and**
- **associated signs and symptoms.**

Brief **and** ***extended*** **HPIs are distinguished by the amount of detail needed to accurately characterize the clinical problem(s).**

A ***brief*** **HPI consists of one to three elements of the HPI.**

- ***DG: The medical record should describe one to three elements of the present illness (HPI).***

An ***extended*** **HPI consists of at least four elements of the HPI or the status of at least three chronic or inactive conditions.**

- ***DG: The medical record should describe at least four elements of the present illness (HPI), or the status of at least three chronic or inactive conditions.***

7

REVIEW OF SYSTEMS (ROS)

A ROS is an inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms that the patient may be experiencing or has experienced.

For purposes of ROS, the following systems are recognized:

- **Constitutional Symptoms (eg, fever, weight loss)**
- **Eyes**
- **Ears, Nose, Mouth, and Throat**
- **Cardiovascular**
- **Respiratory**
- **Gastrointestinal**
- **Genitourinary**
- **Musculoskeletal**
- **Integumentary (skin and/or breast)**
- **Neurological**
- **Psychiatric**
- **Endocrine**
- **Hematologic/Lymphatic**
- **Allergic/Immunologic**

A *problem pertinent* ROS inquires about the system directly related to the problem(s) identified in the HPI.

- ***DG: The patient's positive responses and pertinent negatives for the system related to the problem should be documented.***

An *extended* ROS inquires about the system directly related to the problem(s) identified in the HPI and a limited number of additional systems.

- ***DG: The patient's positive responses and pertinent negatives for two to nine systems should be documented.***

A *complete* ROS inquires about the system(s) directly related to the problem(s) identified in the HPI, *plus* all additional body systems.

- ***DG: At least ten organ systems must be reviewed. Those systems with positive or pertinent negative responses must be individually documented. For the remaining systems, a notation indicating all other systems are negative is permissible. In the absence of such a notation, at least ten systems must be individually documented.***

8

PAST, FAMILY, AND/OR SOCIAL HISTORY (PFSH)

The PFSH consists of a review of three areas:

- past history (the patient's past experiences with illnesses, operations, injuries and treatments);
- family history (a review of medical events in the patient's family, including diseases which maybe hereditary or place the patient at risk); and
- social history (an age appropriate review of past and current activities).

For certain categories of E/M services that include only an interval history, it is not necessary to record information about the PFSH. Those categories are subsequent hospital care, follow-up inpatient consultations and subsequent nursing facility care.

A *pertinent* PFSH is a review of the history area(s) directly related to the problem(s) identified in the HPI.

- *DG: At least one specific item from any of the three history areas must be documented for a pertinent PFSH.*

A *complete* PFSH is a review of two or all three of the PFSH history areas, depending on the category of the E/M service. A review of all three history areas is required for services that by their nature include a comprehensive assessment or reassessment of the patient. A review of two of the three history areas is sufficient for other services.

- *DG: At least one specific item from two of the three history areas must be documented for a complete PFSH for the following categories of E/M services: office or other outpatient services, established patient; emergency department; domiciliary care, established patient; and home care, established patient.*

9

- *DG: At least one specific item from each of the three history areas must be documented for a complete PFSH for the following categories of E/M services: office or other outpatient services, new patient; hospital observation services; hospital inpatient services, initial care; consultations; comprehensive nursing facility assessments; domiciliary care, new patient; home care, new patient.*

B. DOCUMENTATION OF EXAMINATION

The levels of E/M services are based on four types of examination:

- ***Problem Focused*** **– a limited examination of the affected body area or organ system.**

- ***Expanded Problem Focused*** **– a limited examination of the affected body area or organ system and any other symptomatic or related body area(s) or organ system(s).**

- ***Detailed*** **– an extended examination of the affected body area(s) or organ system(s) and any other symptomatic or related body area(s) or organ system(s).**

- ***Comprehensive*** **– a general multi-system examination, or complete examination of a single organ system and other symptomatic or related body area(s) or organ system(s).**

These types of examinations have been defined for general multi-system and the following single organ systems:

- **Cardiovascular**
- **Ears, Nose, Mouth, and Throat**
- **Eyes**
- **Genitourinary (Female)**
- **Genitourinary (Male)**
- **Hematologic/Lymphatic/Immunologic**
- **Musculoskeletal**
- **Neurological**
- **Psychiatric**
- **Respiratory**
- **Skin**

A general multi-system examination or a single organ system examination may be performed by any physician, regardless of specialty. The type (general multi-system or single organ system) and content of examination are selected by the examining physician and are based upon clinical judgment, the patient's history, and the nature of the presenting problem(s).

The content and documentation requirements for each type and level of examination are summarized below and described in detail in tables beginning on page 13. In the tables, organ systems and body areas recognized by CPT for purposes of describing examinations are shown in the left column. The content, or individual elements, of the examination pertaining to that body area or organ system are identified by bullets (•) in the right column.

Parenthetical examples "(eg,...)", have been used for clarification and to provide guidance regarding documentation. Documentation for each element must satisfy any numeric requirements (such as "Measurement of *any three of the following seven...*") included in the description of the element. Elements with multiple components but with no specific numeric requirement (such as "Examination of *liver* and *spleen*") require documentation of at least one component. It is possible for a given examination to be expanded beyond what is defined here. When that occurs, findings related to the additional systems and/or areas should be documented.

- ***DG: Specific abnormal and relevant negative findings of the examination of the affected or symptomatic body area(s) or organ system(s) should be documented. A notation of "abnormal" without elaboration is insufficient.***

- ***DG: Abnormal or unexpected findings of the examination of any asymptomatic body area(s) or organ system(s) should be described.***

- ***DG: A brief statement or notation indicating "negative" or "normal" is sufficient to document normal findings related to unaffected area(s) or asymptomatic organ system(s).***

GENERAL MULTI-SYSTEM EXAMINATIONS

General multi-system examinations are described in detail beginning on page 13. To qualify for a given level of multi-system examination, the following content and documentation requirements should be met:
11

Problem Focused Examination – should include performance and documentation of one to five elements identified by a bullet (•) in one or more organ system(s) or body area(s).

- *Expanded Problem Focused Examination* – should include performance and documentation of at least six elements identified by a bullet (•) in one or more organ system(s) or body area(s).
- *Detailed Examination* – should include at least six organ systems or body areas. For each system/area selected, performance and documentation of at least two elements identified by a bullet (•) is expected. Alternatively, a detailed examination may include performance and documentation of at least twelve elements identified by a bullet (•) in two or more organ systems or body areas.
- *Comprehensive Examination* – should include at least nine organ systems or body areas. For each system/area selected, all elements of the examination identified by a bullet (•) should be performed, unless specific directions limit the content of the examination. For each area/system, documentation of at least two elements identified by a bullet is expected.

SINGLE ORGAN SYSTEM EXAMINATIONS

The single organ system examinations recognized by CPT are described in detail beginning on page 18. Variations among these examinations in the organ systems and body areas identified in the left columns and in the elements of the examinations described in the right columns reflect differing emphases among specialties. To qualify for a given level of single organ system examination, the following content and documentation requirements should be met:

- *Problem Focused Examination* – should include performance and documentation of one to five elements identified by a bullet (•), whether in a box with a shaded or unshaded border.
- *Expanded Problem Focused Examination* – should include performance and documentation of at least six elements identified by a bullet (•), whether in a box with a shaded or unshaded border.
- *Detailed Examination* – examinations other than the eye and psychiatric examinations should include performance and documentation of at least twelve elements identified by a bullet (•), whether in a box with a shaded or unshaded border.

  Eye and psychiatric examinations should include the performance and documentation of at least nine elements identified by a bullet (•), whether in a box with a shaded or unshaded border.

- ***Comprehensive Examination*** **– should include performance of all elements identified by a bullet (•), whether in a shaded or unshaded box. Documentation of every element in each box with a shaded border and at least one element in a box with an unshaded border is expected.**

CONTENT AND DOCUMENTATION REQUIREMENTS

General Multi-System Examination

System/Body Area	Elements of Examination
Constitutional	Measurement of **any three of the following seven** vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded by ancillary staff) General appearance of patient (eg, development, nutrition, body habitus, deformities, attention to grooming)
Eyes	Inspection of conjunctivae and lids Examination of pupils and irises (eg, reaction to light and accommodation, size and symmetry) Ophthalmoscopic examination of optic discs (eg, size, C/D ratio, appearance) and posterior segments (eg, vessel changes, exudates, hemorrhages)
Ears, Nose, Mouth and Throat	External inspection of ears and nose (eg, overall appearance, scars, lesions, masses) Otoscopic examination of external auditory canals and tympanic membranes Assessment of hearing (eg, whispered voice, finger rub, tuning fork) Inspection of nasal mucosa, septum and turbinates Inspection of lips, teeth and gums Examination of oropharynx: oral mucosa, salivary glands, hard and soft palates, tongue, tonsils and posterior pharynx
Neck	Examination of neck (eg, masses, overall appearance, symmetry, tracheal position, crepitus) Examination of thyroid (eg, enlargement, tenderness, mass)

13

System/Body Area	Elements of Examination
Respiratory	Assessment of respiratory effort (eg, intercostal retractions, use of accessory muscles, diaphragmatic movement) Percussion of chest (eg, dullness, flatness, hyperresonance) Palpation of chest (eg, tactile fremitus) Auscultation of lungs (eg, breath sounds, adventitious sounds, rubs)
Cardiovascular	Palpation of heart (eg, location, size, thrills) Auscultation of heart with notation of abnormal sounds and murmurs Examination of: • carotid arteries (eg, pulse amplitude, bruits) • abdominal aorta (eg, size, bruits) • femoral arteries (eg, pulse amplitude, bruits) • pedal pulses (eg, pulse amplitude) • extremities for edema and/or varicosities
Chest (Breasts)	Inspection of breasts (eg, symmetry, nipple discharge) Palpation of breasts and axillae (eg, masses or lumps, tenderness)
Gastrointestinal (Abdomen)	Examination of abdomen with notation of presence of masses or tenderness Examination of liver and spleen Examination for presence or absence of hernia Examination (when indicated) of anus, perineum and rectum, including sphincter tone, presence of hemorrhoids, rectal masses Obtain stool sample for occult blood test when indicated

14

System/Body Area	Elements of Examination
Genitourinary	**MALE:** Examination of the scrotal contents (eg, hydrocele, spermatocele, tenderness of cord, testicular mass) Examination of the penis Digital rectal examination of prostate gland (eg, size, symmetry, nodularity, tenderness) **FEMALE:** Pelvic examination (with or without specimen collection for smears and cultures), including • Examination of external genitalia (eg, general appearance, hair distribution, lesions) and vagina (eg, general appearance, estrogen effect, discharge, lesions, pelvic support, cystocele, rectocele) • Examination of urethra (eg, masses, tenderness, scarring) • Examination of bladder (eg, fullness, masses, tenderness) • Cervix (eg, general appearance, lesions, discharge) Uterus (eg, size, contour, position, mobility, tenderness, consistency, descent or support) Adnexa/parametria (eg, masses, tenderness, organomegaly, nodularity)
Lymphatic	Palpation of lymph nodes in **two or more** areas: Neck Axillae Groin Other

15

System/Body Area	Elements of Examination
Musculoskeletal	Examination of gait and station Inspection and/or palpation of digits and nails (eg, clubbing, cyanosis, inflammatory conditions, petechiae, ischemia, infections, nodes) Examination of joints, bones and muscles of **one or more of the following six** areas: 1) head and neck; 2) spine, ribs and pelvis; 3) right upper extremity; 4) left upper extremity; 5) right lower extremity; and 6) left lower extremity. The examination of a given area includes: • Inspection and/or palpation with notation of presence of any misalignment, asymmetry, crepitation, defects, tenderness, masses, effusions • Assessment of range of motion with notation of any pain, crepitation or contracture • Assessment of stability with notation of any dislocation (luxation), subluxation or laxity • Assessment of muscle strength and tone (eg, flaccid, cog wheel, spastic) with notation of any atrophy or abnormal movements
Skin	Inspection of skin and subcutaneous tissue (eg, rashes, lesions, ulcers) Palpation of skin and subcutaneous tissue (eg, induration, subcutaneous nodules, tightening)
Neurologic	Test cranial nerves with notation of any deficits Examination of deep tendon reflexes with notation of pathological reflexes (eg, Babinski) Examination of sensation (eg, by touch, pin, vibration, proprioception)
Psychiatric	Description of patient's judgment and insight Brief assessment of mental status including: • orientation to time, place and person • recent and remote memory • mood and affect (eg, depression, anxiety, agitation)

16

	Content and Documentation Requirements
Level of Exam	Perform and Document:
Problem Focused	**One to five** elements identified by a bullet.
Expanded Problem Focused	**At least six** elements identified by a bullet.
Detailed	**At least two** elements identified by a bullet **from each of six areas/systems** OR **at least twelve** elements identified by a bullet **in two or more areas/systems**.
Comprehensive	Perform **all elements** identified by a bullet in **at least nine** organ systems or body areas and document **at least two** elements identified by a bullet **from each of nine areas/systems.**

Cardiovascular Examination

System/Body Area	Elements of Examination
Constitutional	Measurement of **any three of the following seven** vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded by ancillary staff) General appearance of patient (eg, development, nutrition, body habitus, deformities, attention to grooming)
Head and Face	
Eyes	Inspection of conjunctivae and lids (eg, xanthelasma)
Ears, Nose, Mouth and Throat	Inspection of teeth, gums and palate Inspection of oral mucosa with notation of presence of pallor or cyanosis
Neck	Examination of jugular veins (eg, distension; a, v or cannon a waves) Examination of thyroid (eg, enlargement, tenderness, mass)
Respiratory	Assessment of respiratory effort (eg, intercostal retractions, use of accessory muscles, diaphragmatic movement) Auscultation of lungs (eg, breath sounds, adventitious sounds, rubs)
Cardiovascular	Palpation of heart (eg, location, size and forcefulness of the point of maximal impact; thrills; lifts; palpable S3 or S4) Auscultation of heart including sounds, abnormal sounds and murmurs Measurement of blood pressure in two or more extremities when indicated (eg, aortic dissection, coarctation) Examination of: • Carotid arteries (eg, waveform, pulse amplitude, bruits, apical-carotid delay) • Abdominal aorta (eg, size, bruits) • Femoral arteries (eg, pulse amplitude, bruits) • Pedal pulses (eg, pulse amplitude) • Extremities for peripheral edema and/or varicosities

System/Body Area	Elements of Examination
Chest (Breasts)	
Gastrointestinal (Abdomen)	Examination of abdomen with notation of presence of masses or tenderness Examination of liver and spleen Obtain stool sample for occult blood from patients who are being considered for thrombolytic or anticoagulant therapy
Genitourinary (Abdomen)	
Lymphatic	
Musculoskeletal	Examination of the back with notation of kyphosis or scoliosis Examination of gait with notation of ability to undergo exercise testing and/or participation in exercise programs Assessment of muscle strength and tone (eg, flaccid, cog wheel, spastic) with notation of any atrophy and abnormal movements
Extremities	Inspection and palpation of digits and nails (eg, clubbing, cyanosis, inflammation, petechiae, ischemia, infections, Osler's nodes)
Skin	Inspection and/or palpation of skin and subcutaneous tissue (eg, stasis dermatitis, ulcers, scars, xanthomas)
Neurological/ Psychiatric	Brief assessment of mental status including • Orientation to time, place and person, • Mood and affect (eg, depression, anxiety, agitation)

Content and Documentation Requirements

Level of Exam	Perform and Document:
Problem Focused	**One to five** elements identified by a bullet.
Expanded Problem Focused	**At least six** elements identified by a bullet.
Detailed	**At least twelve** elements identified by a bullet.
Comprehensive	Perform **all** elements identified by a bullet; document every element in each box with a shaded border and at least one element in each box with an unshaded border.

19

System/Body Area	Elements of Examination
Constitutional	Measurement of **any three of the following seven** vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded by ancillary staff) General appearance of patient (eg, development, nutrition, body habitus, deformities, attention to grooming) Assessment of ability to communicate (eg, use of sign language or other communication aids) and quality of voice
Head and Face	Inspection of head and face (eg, overall appearance, scars, lesions and masses) Palpation and/or percussion of face with notation of presence or absence of sinus tenderness Examination of salivary glands Assessment of facial strength
Eyes	Test ocular motility including primary gaze alignment
Ears, Nose, Mouth and Throat	Otoscopic examination of external auditory canals and tympanic membranes including pneumo-otoscopy with notation of mobility of membranes Assessment of hearing with tuning forks and clinical speech reception thresholds (eg, whispered voice, finger rub) External inspection of ears and nose (eg, overall appearance, scars, lesions and masses) Inspection of nasal mucosa, septum and turbinates Inspection of lips, teeth and gums Examination of oropharynx: oral mucosa, hard and soft palates, tongue, tonsils and posterior pharynx (eg, asymmetry, lesions, hydration of mucosal surfaces) Inspection of pharyngeal walls and pyriform sinuses (eg, pooling of saliva, asymmetry, lesions) Examination by mirror of larynx including the condition of the epiglottis, false vocal cords, true vocal cords and mobility of larynx (Use of mirror not required in children) Examination by mirror of nasopharynx including appearance of the mucosa, adenoids, posterior choanae and eustachian tubes (Use of mirror not required in children)

System/Body Area	Elements of Examination
Neck	Examination of neck (eg, masses, overall appearance, symmetry, tracheal position, crepitus) Examination of thyroid (eg, enlargement, tenderness, mass)
Respiratory	Inspection of chest including symmetry, expansion and/or assessment of respiratory effort (eg, intercostal retractions, use of accessory muscles, diaphragmatic movement) Auscultation of lungs (eg, breath sounds, adventitious sounds, rubs)
Cardiovascular	Auscultation of heart with notation of abnormal sounds and murmurs Examination of peripheral vascular system by observation (eg, swelling, varicosities) and palpation (eg, pulses, temperature, edema, tenderness)
Chest (Breasts)	
Gastrointestinal (Abdomen)	
Genitourinary	
Lymphatic	Palpation of lymph nodes in neck, axillae, groin and/or other location
Musculoskeletal	
Extremities	
Skin	
Neurological/ Psychiatric	Test cranial nerves with notation of any deficits Brief assessment of mental status including • Orientation to time, place and person, • Mood and affect (eg, depression, anxiety, agitation)

21

Content and Documentation Requirements

Level of Exam	Perform and Document:
Problem Focused	**One to five** elements identified by a bullet.
Expanded Problem Focused	**At least six** elements identified by a bullet.
Detailed	**At least twelve** elements identified by a bullet.
Comprehensive	Perform **all** elements identified by a bullet; document every element in each box with a shaded border and at least one element in each box with an unshaded border.

22

System/Body Area	Elements of Examination
Constitutional	
Head and Face	
Eyes	Test visual acuity (Does not include determination of refractive error) Gross visual field testing by confrontation Test ocular motility including primary gaze alignment Inspection of bulbar and palpebral conjunctivae Examination of ocular adnexae including lids (eg, ptosis or lagophthalmos), lacrimal glands, lacrimal drainage, orbits and preauricular lymph nodes Examination of pupils and irises including shape, direct and consensual reaction (afferent pupil), size (eg, anisocoria) and morphology Slit lamp examination of the corneas including epithelium, stroma, endothelium, and tear film Slit lamp examination of the anterior chambers including depth, cells, and flare Slit lamp examination of the lenses including clarity, anterior and posterior capsule, cortex, and nucleus Measurement of intraocular pressures (except in children and patients with trauma or infectious disease) Ophthalmoscopic examination through dilated pupils (unless contraindicated) of • Optic discs including size, C/D ratio, appearance (eg, atrophy, cupping, tumor elevation) and nerve fiber layer • Posterior segments including retina and vessels (eg, exudates and hemorrhages)
Ears, Nose, Mouth and Throat	
Neck	
Respiratory	

23

System/Body Area	Elements of Examination
Cardiovascular	
Chest (Breasts)	
Gastrointestinal (Abdomen)	
Genitourinary	
Lymphatic	
Musculoskeletal	
Extremities	
Skin	
Neurological/ Psychiatric	Brief assessment of mental status including • Orientation to time, place and person • Mood and affect (eg, depression, anxiety, agitation)

Content and Documentation Requirements

Level of Exam	Perform and Document:
Problem Focused	**One to five** elements identified by a bullet.
Expanded Problem Focused	**At least six** elements identified by a bullet.
Detailed	**At least nine** elements identified by a bullet.
Comprehensive	Perform **all** elements identified by a bullet; document every element in each box with a shaded border and at least one element in each box with an unshaded border.

System/Body Area	Elements of Examination
Constitutional	Measurement of **any three of the following seven** vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded by ancillary staff) General appearance of patient (eg, development, nutrition, body habitus, deformities, attention to grooming)
Head and Face	
Eyes	
Ears, Nose, Mouth and Throat	
Neck	Examination of neck (eg, masses, overall appearance, symmetry, tracheal position, crepitus) Examination of thyroid (eg, enlargement, tenderness, mass)
Respiratory	Assessment of respiratory effort (eg, intercostal retractions, use of accessory muscles, diaphragmatic movement) Auscultation of lungs (eg, breath sounds, adventitious sounds, rubs)
Cardiovascular	Auscultation of heart with notation of abnormal sounds and murmurs palpation (eg, pulses, temperature, edema, tenderness)
Chest (Breasts)	[See genitourinary (female)]
Gastrointestinal (Abdomen)	Examination of abdomen with notation of presence of masses or tenderness Examination for presence or absence of hernia Examination of liver and spleen Obtain stool sample for occult blood test when indicated

System/Body Area	Elements of Examination
Genitourinary	**MALE:** • Inspection of anus and perineum Examination (with or without specimen collection for smears and cultures) of genitalia including: • Scrotum (eg, lesions, cysts, rashes) • Epididymides (eg, size, symmetry, masses) • Testes (eg, size, symmetry, masses) • Urethral meatus (eg, size, location, lesions, discharge) • Penis (eg, lesions, presence or absence of foreskin, foreskin retractability, plaque, masses, scarring, deformities) Digital rectal examination including: • Prostate gland (eg, size, symmetry, nodularity, tenderness) • Seminal vesicles (eg, symmetry, tenderness, masses, enlargement) • Sphincter tone, presence of hemorrhoids, rectal masses

26

System/Body Area	Elements of Examination
Genitourinary (Cont'd)	**FEMALE:** Includes **at least seven of the following eleven** elements identified by bullets: • Inspection and palpation of breasts (eg, masses or lumps, tenderness, symmetry, nipple discharge) • Digital rectal examination including sphincter tone, presence of hemorrhoids, rectal masses Pelvic examination (with or without specimen collection for smears and cultures) including: • External genitalia (eg, general appearance, hair distribution, lesions) Urethral meatus (eg, size, location, lesions, prolapse) • Urethra (eg, masses, tenderness, scarring) • Bladder (eg, fullness, masses, tenderness) • Vagina (eg, general appearance, estrogen effect, discharge, lesions, pelvic support, cystocele, rectocele) • Cervix (eg, general appearance, lesions, discharge) • Uterus (eg, size, contour, position, mobility, tenderness, consistency, descent or support) • Adnexa/parametria (eg, masses, tenderness, organomegaly, nodularity) • Anus and perineum
Lymphatic	• Palpation of lymph nodes in neck, axillae, groin and/or other location
Musculoskeletal	
Extremities	
Skin	• Inspection and/or palpation of skin and subcutaneous tissue (eg, rashes, lesions, ulcers)
Neurological/ Psychiatric	Brief assessment of mental status including • Orientation (eg, time, place and person) and • Mood and affect (eg, depression, anxiety, agitation)

27

Content and Documentation Requirements

Level of Exam	Perform and Document:
Problem Focused	**One to five** elements identified by a bullet.
Expanded Problem Focused	**At least six** elements identified by a bullet.
Detailed	**At least twelve** elements identified by a bullet.
Comprehensive	Perform **all** elements identified by a bullet; document every element in each box with a shaded border and at least one element in each box with an unshaded border.

28

Hematologic/Lymphatic/Immunologic Examination

System/Body Area	Elements of Examination
Constitutional	Measurement of **any three of the following seven** vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded by ancillary staff) General appearance of patient (eg, development, nutrition, body habitus, deformities, attention to grooming)
Head and Face	Palpation and/or percussion of face with notation of presence or absence of sinus tenderness
Eyes	Inspection of conjunctivae and lids
Ears, Nose, Mouth and Throat	Otoscopic examination of external auditory canals and tympanic membranes Inspection of nasal mucosa, septum and turbinates Inspection of teeth and gums Examination of oropharynx (eg, oral mucosa, hard and soft palates, tongue, tonsils, posterior pharynx)
Neck	• Examination of neck (eg, masses, overall appearance, symmetry, tracheal position, crepitus) • Examination of thyroid (eg, enlargement, tenderness, mass)
Respiratory	Assessment of respiratory effort (eg, intercostal retractions, use of accessory muscles, diaphragmatic movement) Auscultation of lungs (eg, breath sounds, adventitious sounds, rubs)
Cardiovascular	Auscultation of heart with notation of abnormal sounds and murmurs Examination of peripheral vascular system by observation (eg, swelling, varicosities) and palpation (pulses, temperature, edema, tenderness)
Chest (Breasts)	
Gastrointestinal (Abdomen)	Examination of abdomen with notation of presence of masses or tenderness Examination of liver and spleen
Genitourinary	

29

System/Body Area	Elements of Examination
Lymphatic	Palpation of lymph nodes in neck, axillae, groin, and/or other location
Musculoskeletal	
Extremities	Inspection and palpation of digits and nails (eg, clubbing, cyanosis, inflammation, petechiae, ischemia, infections, nodes)
Skin	Inspection and/or palpation of skin and subcutaneous tissue (eg, rashes, lesions, ulcers, ecchymoses, bruises)
Neurological/ Psychiatric	Brief assessment of mental status including • Orientation to time, place and person • Mood and affect (eg, depression, anxiety, agitation)

Content and Documentation Requirements

Level of Exam	Perform and Document:
Problem Focused	**One to five** elements identified by a bullet.
Expanded Problem Focused	**At least six** elements identified by a bullet.
Detailed	**At least twelve** elements identified by a bullet.
Comprehensive	Perform **all** elements identified by a bullet; document every element in each box with a shaded border and at least one element in each box with an unshaded border.

30

System/Body Area	Elements of Examination
Constitutional	Measurement of **any three of the following seven** vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded by ancillary staff) General appearance of patient (eg, development, nutrition, body habitus, deformities, attention to grooming)
Head and Face	
Eyes	
Ears, Nose, Mouth and Throat	
Neck	
Respiratory	
Cardiovascular	Examination of peripheral vascular system by observation (eg, swelling, varicosities) and palpation (eg, pulses, temperature, edema, tenderness)
Chest (Breasts)	
Gastrointestinal (Abdomen)	
Genitourinary	
Lymphatic	Palpation of lymph nodes in neck, axillae, groin and/or other location

System/Body Area	Elements of Examination
Musculoskeletal	Examination of gait and station Examination of joint(s), bone(s) and muscle(s)/ tendon(s) of **four of the following six** areas: 1) head and neck; 2) spine, ribs and pelvis; 3) right upper extremity; 4) left upper extremity; 5) right lower extremity; and 6) left lower extremity. The examination of a given area includes: • Inspection, percussion and/or palpation with notation of any misalignment, asymmetry, crepitation, defects, tenderness, masses or effusions • Assessment of range of motion with notation of any pain (eg, straight leg raising), crepitation or contracture • Assessment of stability with notation of any dislocation (luxation), subluxation or laxity • Assessment of muscle strength and tone (eg, flaccid, cog wheel, spastic) with notation of any atrophy or abnormal movements NOTE: For the comprehensive level of examination, all four of the elements identified by a bullet must be performed and documented for each of four anatomic areas. For the three lower levels of examination, each element is counted separately for each body area. For example, assessing range of motion in two extremities constitutes two elements.
Extremities	[See musculoskeletal and skin]
Skin	Inspection and/or palpation of skin and subcutaneous tissue (eg, scars, rashes, lesions, cafe-au-lait spots, ulcers) in **four of the following six** areas: 1) head and neck; 2) trunk; 3) right upper extremity; 4) left upper extremity; 5) right lower extremity; and 6) left lower extremity. NOTE: For the comprehensive level, the examination of all four anatomic areas must be performed and documented. For the three lower levels of examination, each body area is counted separately. For example, inspection and/or palpation of the skin and subcutaneous tissue of two extremities constitutes two elements.
Neurological/ Psychiatric	Test coordination (eg, finger/nose, heel/ knee/shin, rapid alternating movements in the upper and lower extremities, evaluation of fine motor coordination in young children) Examination of deep tendon reflexes and/or nerve stretch test with notation of pathological reflexes (eg, Babinski) Examination of sensation (eg, by touch, pin, vibration, proprioception) Brief assessment of mental status including • Orientation to time, place and person • Mood and affect (eg, depression, anxiety, agitation)

	Content and Documentation Requirements
Level of Exam	Perform and Document:
Problem Focused	**One to five** elements identified by a bullet.
Expanded Problem Focused	**At least six** elements identified by a bullet.
Detailed	**At least twelve** elements identified by a bullet.
Comprehensive	Perform **all** elements identified by a bullet; document every element in each box with a shaded border and at least one element in each box with an unshaded border.

System/Body Area	Elements of Examination
Constitutional	Measurement of **any three of the following seven** vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded by ancillary staff) General appearance of patient (eg, development, nutrition, body habitus, deformities, attention to grooming)
Head and Face	
Eyes	• Ophthalmoscopic examination of optic discs (eg, size, C/D ratio, appearance) and posterior segments (eg, vessel changes, exudates, hemorrhages)
Ears, Nose, Mouth and Throat	
Neck	
Respiratory	
Cardiovascular	• Examination of carotid arteries (eg, pulse amplitude, bruits) Auscultation of heart with notation of abnormal sounds and murmurs Examination of peripheral vascular system by observation (eg, swelling, varicosities) and palpation (eg, pulses, temperature, edema, tenderness)
Chest (Breasts)	
Gastrointestinal (Abdomen)	
Genitourinary	
Lymphatic	

System/Body Area	Elements of Examination
Musculoskeletal	Examination of gait and station Assessment of motor function including: • Muscle strength in upper and lower extremities • Muscle tone in upper and lower extremities (eg, flaccid, cog wheel, spastic) with notation of any atrophy or abnormal movements (eg, fasciculation, tardive dyskinesia)
Extremities	[See musculoskeletal]
Skin	
Neurological	Evaluation of higher integrative functions including: • Orientation to time, place and person • Recent and remote memory • Attention span and concentration • Language (eg, naming objects, repeating phrases, spontaneous speech) • Fund of knowledge (eg, awareness of current events, past history, vocabulary) Test the following cranial nerves: • 2nd cranial nerve (eg, visual acuity, visual fields, fundi) • 3rd, 4th and 6th cranial nerves (eg, pupils, eye movements) • 5th cranial nerve (eg, facial sensation, corneal reflexes) • 7th cranial nerve (eg, facial symmetry, strength) • 8th cranial nerve (eg, hearing with tuning fork, whispered voice and/or finger rub) • 9th cranial nerve (eg, spontaneous or reflex palate movement) • 11th cranial nerve (eg, shoulder shrug strength) • 12th cranial nerve (eg, tongue protrusion) Examination of sensation (eg, by touch, pin, vibration, proprioception) Examination of deep tendon reflexes in upper and lower extremities with notation of pathological reflexes (eg, Babinski) Test coordination (eg, finger/nose, heel/knee/shin, rapid alternating movements in the upper and lower extremities, evaluation of fine motor coordination in young children)
Psychiatric	

35

Content and Documentation Requirements

Level of Exam	Perform and Document:
Problem Focused	**One to five** elements identified by a bullet.
Expanded Problem Focused	**At least six** elements identified by a bullet.
Detailed	**At least twelve** elements identified by a bullet.
Comprehensive	Perform **all** elements identified by a bullet; document every element in each box with a shaded border and at least one element in each box with an unshaded border.

System/Body Area	Elements of Examination
Constitutional	Measurement of **any three of the following seven** vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded by ancillary staff) General appearance of patient (eg, development, nutrition, body habitus, deformities, attention to grooming)
Head and Face	
Eyes	
Ears, Nose, Mouth and Throat	
Neck	
Respiratory	
Cardiovascular	
Chest (Breasts)	
Gastrointestinal (Abdomen)	
Genitourinary	
Lymphatic	
Musculoskeletal	Assessment of muscle strength and tone (eg, flaccid, cog wheel, spastic) with notation of any atrophy and abnormal movements Examination of gait and station
Extremities	
Skin	
Neurological	

37

System/Body Area	Elements of Examination
Psychiatric	

- Description of speech including: rate; volume; articulation; coherence; and spontaneity with notation of abnormalities (eg, perseveration, paucity of language)
- Description of thought processes including: rate of thoughts; content of thoughts (eg, logical vs. illogical, tangential); abstract reasoning; and computation
- Description of associations (eg, loose, tangential, circumstantial, intact)
- Description of abnormal or psychotic thoughts including: hallucinations; delusions; preoccupation with violence; homicidal or suicidal ideation; and obsessions
- Description of the patient's judgment (eg, concerning everyday activities and social situations) and insight (eg, concerning psychiatric condition)

Complete mental status examination including

- Orientation to time, place and person
- Recent and remote memory
- Attention span and concentration
- Language (eg, naming objects, repeating phrases)
- Fund of knowledge (eg, awareness of current events, past history, vocabulary)
- Mood and affect (eg, depression, anxiety, agitation, hypomania, lability)

Content and Documentation Requirements

Level of Exam	Perform and Document:
Problem Focused	**One to five** elements identified by a bullet.
Expanded Problem Focused	**At least six** elements identified by a bullet.
Detailed	**At least nine** elements identified by a bullet.
Comprehensive	Perform **all** elements identified by a bullet; document every element in each box with a shaded border and at least one element in each box with an unshaded border.

Respiratory Examination

System/Body Area	Elements of Examination
Constitutional	Measurement of **any three of the following seven** vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded by ancillary staff) General appearance of patient (eg, development, nutrition, body habitus, deformities, attention to grooming)
Head and Face	
Eyes	
Ears, Nose, Mouth and Throat	Inspection of nasal mucosa, septum and turbinates Inspection of teeth and gums Examination of oropharynx (eg, oral mucosa, hard and soft palates, tongue, tonsils and posterior pharynx)
Neck	Examination of neck (eg, masses, overall appearance, symmetry, tracheal position, crepitus) Examination of thyroid (eg, enlargement, tenderness, mass) Examination of jugular veins (eg, distension; a, v or cannon a waves)
Respiratory	Inspection of chest with notation of symmetry and expansion Assessment of respiratory effort (eg, intercostal retractions, use of accessory muscles, diaphragmatic movement) Percussion of chest (eg, dullness, flatness, hyperresonance) Palpation of chest (eg, tactile fremitus) Auscultation of lungs (eg, breath sounds, adventitious sounds, rubs)
Cardiovascular	Auscultation of heart including sounds, abnormal sounds and murmurs Examination of peripheral vascular system by observation (eg, swelling, varicosities) and palpation (eg, pulses, temperature, edema, tenderness)
Chest (Breasts)	

System/Body Area	Elements of Examination
Gastrointestinal (Abdomen)	Examination of abdomen with notation of presence of masses or tenderness Examination of liver and spleen
Genitourinary	
Lymphatic	Palpation of lymph nodes in neck, axillae, groin and/or other location
Musculoskeletal	Assessment of muscle strength and tone (eg, flaccid, cog wheel, spastic) with notation of any atrophy and abnormal movements Examination of gait and station
Extremities	Inspection and palpation of digits and nails (eg, clubbing, cyanosis, inflammation, petechiae, ischemia, infections, nodes)
Skin	Inspection and/or palpation of skin and subcutaneous tissue (eg, rashes, lesions, ulcers)
Neurological/ Psychiatric	Brief assessment of mental status including • Orientation to time, place and person • Mood and affect (eg, depression, anxiety, agitation)

Content and Documentation Requirements

Level of Exam	Perform and Document:
Problem Focused	**One to five** elements identified by a bullet.
Expanded Problem Focused	**At least six** elements identified by a bullet.
Detailed	**At least twelve** elements identified by a bullet.
Comprehensive	Perform **all** elements identified by a bullet; document every element in each box with a shaded border and at least one element in each box with an unshaded border.

40

System/Body Area	Elements of Examination
Constitutional	Measurement of any **three of the following seven** vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded by ancillary staff) General appearance of patient (eg, development, nutrition, body habitus, deformities, attention to grooming)
Head and Face	
Eyes	Inspection of conjunctivae and lids
Ears, Nose, Mouth and Throat	Inspection of lips, teeth and gums Examination of oropharynx (eg, oral mucosa, hard and soft palates, tongue, tonsils, posterior pharynx)
Neck	Examination of thyroid (eg, enlargement, tenderness, mass)
Respiratory	
Cardiovascular	Examination of peripheral vascular system by observation (eg, swelling, varicosities) and palpation (eg, pulses, temperature, edema, tenderness)
Chest (Breasts)	
Gastrointestinal (Abdomen)	Examination of liver and spleen Examination of anus for condyloma and other lesions
Genitourinary	
Lymphatic	Palpation of lymph nodes in neck, axillae, groin and/or other location
Musculoskeletal	
Extremities	Inspection and palpation of digits and nails (eg, clubbing, cyanosis, inflammation, petechiae, ischemia, infections, nodes)

Skin Examination

System/Body Area	Elements of Examination
Skin	Palpation of scalp and inspection of hair of scalp, eyebrows, face, chest, pubic area (when indicated) and extremities Inspection and/or palpation of skin and subcutaneous tissue (eg, rashes, lesions, ulcers, susceptibility to and presence of photo damage) in **eight of the following ten** areas: Head, including the face and Neck Chest, including breasts and axillae Abdomen Genitalia, groin, buttocks Back Right upper extremity Left upper extremity Right lower extremity Left lower extremity NOTE: For the comprehensive level, the examination of at least eight anatomic areas must be performed and documented. For the three lower levels of examination, each body area is counted separately. For example, inspection and/or palpation of the skin and subcutaneous tissue of the right upper extremity and the left upper extremity constitutes two elements. Inspection of eccrine and apocrine glands of skin and subcutaneous tissue with identification and location of any hyperhidrosis, chromhidroses or bromhidrosis
Neurological/ Psychiatric	Brief assessment of mental status including • Orientation to time, place and person • Mood and affect (eg, depression, anxiety, agitation)

Content and Documentation Requirements

Level of Exam	Perform and Document:
Problem Focused	**One to five** elements identified by a bullet.
Expanded Problem Focused	**At least six** elements identified by a bullet.
Detailed	**At least twelve** elements identified by a bullet.
Comprehensive	Perform **all** elements identified by a bullet; document every element in each box with a shaded border and at least one element in each box with an unshaded border.

C. DOCUMENTATION OF THE COMPLEXITY OF MEDICAL DECISION MAKING

The levels of E/M services recognize four types of medical decision making (straightforward, low complexity, moderate complexity and high complexity). Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option as measured by:

- the number of possible diagnoses and/or the number of management options that must be considered;
- the amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed and analyzed; and
- the risk of significant complications, morbidity and/or mortality, as well as comorbidities, associated with the patient's presenting problem(s), the diagnostic procedure(s) and/or the possible management options.

The chart below shows the progression of the elements required for each level of medical decision making. To qualify for a given type of decision making, **two of the three elements in the table must be either met or exceeded.**

Number of diagnoses or management options	Amount and/or complexity of data to be reviewed	Risk of complications and/or morbidity or mortality	Type of decision making
Minimal	Minimal or None	Minimal	***Straightforward***
Limited	Limited	Low	***Low Complexity***
Multiple	Moderate	Moderate	***Moderate Complexity***
Extensive	Extensive	High	***High Complexity***

Each of the elements of medical decision making is described below.

NUMBER OF DIAGNOSES OR MANAGEMENT OPTIONS

The number of possible diagnoses and/or the number of management options that must be considered is based on the number and types of problems addressed during the encounter, the complexity of establishing a diagnosis and the management decisions that are made by the physician.

Generally, decision making with respect to a diagnosed problem is easier than that for an identified but undiagnosed problem. The number and type of diagnostic tests employed may be an indicator of the number of possible diagnoses. Problems which are improving or resolving are less complex than those which are worsening or failing to change as expected. The need to seek advice from others is another indicator of complexity of diagnostic or management problems.

DG: *For each encounter, an assessment, clinical impression, or diagnosis should be documented. It may be explicitly stated or implied in documented decisions regarding management plans and/or further evaluation.*

- *For a presenting problem with an established diagnosis the record should reflect whether the problem is: a) improved, well controlled, resolving or resolved; or, b) inadequately controlled, worsening, or failing to change as expected.*
- *For a presenting problem without an established diagnosis, the assessment or clinical impression may be stated in the form of differential diagnoses or as a "possible", "probable", or "rule out" (R/O) diagnosis.*

DG: *The initiation of, or changes in, treatment should be documented. Treatment includes a wide range of management options including patient instructions, nursing instructions, therapies, and medications.*

DG: *If referrals are made, consultations requested or advice sought, the record should indicate to whom or where the referral or consultation is made or from whom the advice is requested.*

44

AMOUNT AND/OR COMPLEXITY OF DATA TO BE REVIEWED

The amount and complexity of data to be reviewed is based on the types of diagnostic testing ordered or reviewed. A decision to obtain and review old medical records and/or obtain history from sources other than the patient increases the amount and complexity of data to be reviewed.

Discussion of contradictory or unexpected test results with the physician who performed or interpreted the test is an indication of the complexity of data being reviewed. On occasion the physician who ordered a test may personally review the image, tracing or specimen to supplement information from the physician who prepared the test report or interpretation; this is another indication of the complexity of data being reviewed.

DG: *If a diagnostic service (test or procedure) is ordered, planned, scheduled, or performed at the time of the E/M encounter, the type of service, eg, lab or x-ray, should be documented.*

DG: *The review of lab, radiology and/or other diagnostic tests should be documented. A simple notation such as "WBC elevated" or "chest x-ray unremarkable" is acceptable. Alternatively, the review may be documented by initialing and dating the report containing the test results.*

DG: *A decision to obtain old records or decision to obtain additional history from the family, caretaker or other source to supplement that obtained from the patient should be documented.*

DG: *Relevant findings from the review of old records, and/or the receipt of additional history from the family, caretaker or other source to supplement that obtained from the patient should be documented. If there is no relevant information beyond that already obtained, that fact should be documented. A notation of "Old records reviewed" or "additional history obtained from family" without elaboration is insufficient.*

DG: *The results of discussion of laboratory, radiology or other diagnostic tests with the physician who performed or interpreted the study should be documented.*

DG: *The direct visualization and independent interpretation of an image, tracing or specimen previously or subsequently interpreted by another physician should be documented.*

45

RISK OF SIGNIFICANT COMPLICATIONS, MORBIDITY, AND/OR MORTALITY

The risk of significant complications, morbidity, and/or mortality is based on the risks associated with the presenting problem(s), the diagnostic procedure(s), and the possible management options.

DG: *Comorbidities/underlying diseases or other factors that increase the complexity of medical decision making by increasing the risk of complications, morbidity, and/or mortality should be documented.*

DG: *If a surgical or invasive diagnostic procedure is ordered, planned or scheduled at the time of the E/M encounter, the type of procedure, eg, laparoscopy, should be documented.*

DG: *If a surgical or invasive diagnostic procedure is performed at the time of the E/M encounter, the specific procedure should be documented.*

DG: *The referral for or decision to perform a surgical or invasive diagnostic procedure on an urgent basis should be documented or implied.*

The following table may be used to help determine whether the risk of significant complications, morbidity, and/or mortality is *minimal*, *low*, *moderate*, or *high*. Because the determination of risk is complex and not readily quantifiable, the table includes common clinical examples rather than absolute measures of risk. The assessment of risk of the presenting problem(s) is based on the risk related to the disease process anticipated between the present encounter and the next one. The assessment of risk of selecting diagnostic procedures and management options is based on the risk during and immediately following any procedures or treatment. **The highest level of risk in any one category (presenting problem(s), diagnostic procedure(s), or management options) determines the overall risk.**

TABLE OF RISK

Level of Risk	Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Management Options Selected
Minimal	One self-limited or minor problem, eg, cold, insect bite, tinea corporis	Laboratory tests requiring venipuncture Chest x-rays EKG/EEG Urinalysis Ultrasound, eg, echocardiography KOH prep	Rest Gargles Elastic bandages Superficial dressings
Low	Two or more self-limited or minor problems One stable chronic illness, eg, well controlled hypertension, non-insulin dependent diabetes, cataract, BPH Acute uncomplicated illness or injury, eg, cystitis, allergic rhinitis, simple sprain	Physiologic tests not under stress, eg, pulmonary function tests Non-cardiovascular imaging studies with contrast, eg, barium enema Superficial needle biopsies Clinical laboratory tests requiring arterial puncture Skin biopsies	Over-the-counter drugs Minor surgery with no identified risk factors Physical therapy Occupational therapy IV fluids without additives
Moderate	One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment Two or more stable chronic illnesses Undiagnosed new problem with uncertain prognosis, eg, lump in breast Acute illness with systemic symptoms, eg, pyelonephritis, pneumonitis, colitis Acute complicated injury, eg, head injury with brief loss of consciousness	Physiologic tests under stress, eg, cardiac stress test, fetal contraction stress test Diagnostic endoscopies with no identified risk factors Deep needle or incisional biopsy Cardiovascular imaging studies with contrast and no identified risk factors, eg, arteriogram, cardiac catheterization Obtain fluid from body cavity, eg lumbar puncture, thoracentesis, culdocentesis	Minor surgery with identified risk factors Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors Prescription drug management Therapeutic nuclear medicine IV fluids with additives Closed treatment of fracture or dislocation without manipulation
High	One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment Acute or chronic illnesses or injuries that pose a threat to life or bodily function, eg, multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure An abrupt change in neurologic status, eg, seizure, TIA, weakness, sensory loss	Cardiovascular imaging studies with contrast with identified risk factors Cardiac electrophysiological tests Diagnostic Endoscopies with identified risk factors Discography	Elective major surgery (open, percutaneous or endoscopic) with identified risk factors Emergency major surgery (open, percutaneous or endoscopic) Parenteral controlled substances Drug therapy requiring intensive monitoring for toxicity Decision not to resuscitate or to de-escalate care because of poor prognosis

47

D. DOCUMENTATION OF AN ENCOUNTER DOMINATED BY COUNSELING OR COORDINATION OF CARE

In the case where counseling and/or coordination of care dominates (more than 50%) of the physician/patient and/or family encounter (face-to-face time in the office or other or outpatient setting, floor/unit time in the hospital or nursing facility), time is considered the key or controlling factor to qualify for a particular level of E/M services.

DG: *If the physician elects to report the level of service based on counseling and/or coordination of care, the total length of time of the encounter (face-to-face or floor time, as appropriate) should be documented and the record should describe the counseling and/or activities to coordinate care.*

CHAPTER 6

PROTECTING THE MEDICARE TRUST FUND

This chapter provides an overview regarding how the Medicare Trust Fund is protected.

The goal of the Medicare Integrity Program (MIP) is to pay it right – pay the right amount, to the right provider or supplier, for the right service, to the right beneficiary. Some of the MIP or payment safeguard activities that Medicare Contractors complete are:

- Data analysis;
- Medical review (MR);
- Anti-fraud; and
- Medicare Secondary Payer (MSP) (see Chapter 3 for information about MSP activities).

Data Analysis

Data analysis is an integrated, on-going component of MR and benefit integrity (BI) activities which involves:

- Collecting data from:
    - Historical data (e.g., review experience, denial data, provider billing problems, provider cost report data, provider statistical and reimbursement data, billing data, Common Working File, and data from other Federal sources such as Quality Improvement Organizations [QIO], Medicare Contractors, and Medicaid) and
    - Referrals from internal or external sources (e.g., provider audit, BI unit, beneficiary, and other complaints)
- Identifying potential errors; and
- Instituting ongoing monitoring and modification of data analysis program components.

Medical Review

The MR process includes the following:

- Reviewing claims appropriately submitted to Medicare Contractors when atypical billing patterns or particular kinds of problems (e.g., errors in billing a specific type of service) are identified. QIOs conduct reviews of Acute Care Inpatient Hospital Prospective Payment System Diagnosis Related Group and Long Term Care Hospital claims.

- Ensuring that MR activities are targeted at identified problem areas and that the corrective actions imposed are appropriate for the severity of the problem through Progressive Corrective Actions. Providers with identified problems submitting correct claims may be subject to three types of corrective actions:
    - Education about appropriate billing procedures (problems at all levels require education)
    - Prepayment review, which is when claims are subject to MR before payment of the claim can be authorized (a percentage of claims may be subject to this corrective action) and
    - Postpayment review, which occurs after the claim has been paid

- Validating claim errors through the use of probe reviews. Providers are notified when probe reviews are conducted, asked to provide medical documentation for the claim(s) in question, and notified of the results of the probe review. Probe reviews can either:
    - Examine 20 – 40 claims per provider for provider-specific problems or
    - Examine approximately 100 claims from multiple providers for widespread, larger problems such as a spike in billing for a specific procedure

- When a probe review verifies that an error exists, the following occurs:
    - The severity of the problem is classified as minor, moderate, or significant which is determined by the provider-specific error rate (number of claims paid in error), dollar amounts improperly paid, and past billing history
    - Overpayments are collected and
    - A determination is made as to what steps need to be taken to correct the problem

Submission of medical records is required in a small number of cases for prepayment, postpayment, and probe reviews. A review of the medical records confirms that the services furnished are reflected on the claim, coded correctly, and covered by Medicare. Most MR does not require the review of medical records. If medical records are requested, they must be submitted within the specified timeframe or the claim will be denied. In some instances, claim attachments will be reviewed (e.g., Certificates of Medical Necessity and patient history files).

Providers can create medical record documentation that assists the MR process by ensuring that:

- Documentation is provided, when requested, for every service selected for MR;
- Documentation demonstrates that the patient's condition warrants the type and amount of services furnished;
- Documentation is legible; and
- Each service is coded correctly.

Providers can assist in the MR process by:

- Becoming familiar with coverage requirements;
- Ensuring that office staff and billing vendors are familiar with claim filing rules;
- Comparing records and billed claims;
- Creating a patient educational awareness campaign that explains Medicare coverage limitations and medical necessity requirements; and
- Performing mock record audits to ensure that documentation reflects requirements outlined in Medicare coverage policies.

Coverage Determinations

There are two types of coverage policies that assist providers and suppliers in coding correctly and billing Medicare only for covered items and services.

1) National Coverage Determinations (NCD)

A NCD sets forth the extent to which Medicare will cover specific services, procedures, or technologies on a national basis. Medicare Contractors are required to follow NCDs. Prior to an NCD taking effect, the Centers for Medicare & Medicaid Services (CMS) must first issue a Manual Transmittal, ruling, or *Federal Register* Notice. If a NCD and a Local Coverage Determination (LCD) exist concurrently regarding the same coverage policy, the NCD takes precedence.

Formal requests for NCDs may be submitted at *www.cms.hhs.gov/center/coverage.asp* on the CMS website or in writing to:

CMS
Coverage and Analysis Group
7500 Security Boulevard (Mailstop C1-09-06)
Baltimore, MD 21244

When formal requests are accepted and posted, the public may submit evidence or other comments relevant to the request at www.cms.hhs.gov/center/coverage.asp on the CMS website for a period of 30 days in accordance with §522(b) of the Benefits Improvement and Protection Act of 2000.

Drafts of proposed decisions are posted at www.cms.hhs.gov/center/coverage.asp on the CMS website, at which time the public may comment for a period of 30 days. Comments are reviewed and a final decision memorandum, which includes a summary and responses to public comments, is issued no later than 60 days after the conclusion of the comment period.

2) LCDs (formerly known as Local Medical Review Policies)

In the absence of a specific NCD, local Medicare Contractors may make LCDs, which are coverage decisions made at their own discretion to provide guidance to the public and the medical community within a specified geographic area. LCDs outline coverage criteria, define medical necessity, provide codes that describe what is and is not covered when the codes are integral to the discussion of medical necessity, and provide references upon which a policy is based. CMS reviews LCDs to ensure that they do not conflict with NCDs. Providers and suppliers may submit requests for new or revised LCDs to Medicare Contractors. The LCD development process is open to the public and includes:

- Developing a draft;
- Making the draft available to the public; and
- Soliciting comments about the draft from the public, which can be electronically submitted on Medicare Contractor's websites.

NCDs and LCDs that may prevent access to items and services or have resulted in claim denials can be challenged by aggrieved parties (Medicare beneficiaries or the estate of Medicare beneficiaries) who:

- Are entitled to benefits under Part A, are enrolled in Part B, or both (including beneficiaries who are enrolled in fee-for-service Medicare and Medicare Advantage);
- Are in need of coverage for items or services that are denied based upon an applicable LCD or NCD, regardless of whether the items or services were received; and
- Have obtained documentation of the need for the items or services from his or her treating physician.

If a claim is denied by a Medicare Contractor based on a NCD or LCD, the beneficiary is notified about the denial and the reasons for the denial on the Medicare Summary Notice.

Information about NCDs is available in the National Coverage Determinations Manual (Publication 100-03) at *www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage* on the CMS website.

Fraud and Abuse

CMS emphasizes early detection and prevention of fraud and abuse. An estimated 10 percent of Medicare costs are wrongly spent on incidences of fraud and abuse. Preventing and detecting fraud and abuse is a cooperative effort that involves:

- CMS;
- Beneficiaries;
- Medicare Contractors;
- Providers, suppliers, and other health care entities;
- State Medicaid Fraud Control Units;
- QIOs;
- Department of Health and Human Services Office of Inspector General (OIG);
- Department of Justice (DOJ), including the Federal Bureau of Investigation; and
- Other Federal law enforcement agencies.

The efforts of these groups can help deter health care fraud and abuse and protect beneficiaries from harm by:

- Identifying suspicious Medicare charges and activities;
- Investigating and punishing those who commit Medicare fraud and abuse; and
- Ensuring that money lost to fraud and abuse is returned to the Medicare Trust Fund.

Federal health care fraud generally involves a person or entity's intentional use of false statements or fraudulent schemes (such as kickbacks) to obtain payment for, or to cause another to obtain payment for, items or services payable under a Federal health care program. Some examples of fraud are:

- Billing for services not furnished;
- Soliciting, offering, or receiving a kickback, bribe, or rebate;
- Violations of the physician self-referral ("Stark") prohibition;
- Using an incorrect or inappropriate Provider Identification Number (PIN) in order to be paid (e.g., using a deceased provider's PIN);
- Signing blank records or certification forms that are used by another entity to obtain Medicare payment;
- Selling, sharing, or purchasing Medicare Health Insurance Claim numbers in order to bill false claims to the Medicare Program;
- Offering incentives to Medicare patients that are not offered to other patients (e.g., routinely waiving or discounting Medicare deductibles, coinsurance, or copayments);
- Falsifying information on applications, medical records, billing statements, cost reports, or on any statement filed with the government;
- Using inappropriate procedure or diagnosis codes to misrepresent the medical necessity or coverage status of the services furnished; and
- Consistently using billing or revenue codes that describe more extensive services than those actually performed ("upcoding").

In general, program abuse, which may be intentional or unintentional, directly or indirectly results in unnecessary or increased costs to the Medicare Program. Many abusive practices are subsequently determined to be fraudulent. For example, if a provider or supplier ignores Medicare guidance, education efforts, warnings, or advice that abusive conduct is inappropriate and he or she continues to engage in the same or similar conduct, the conduct could be considered fraudulent.

Significant Medicare Fraud and Abuse Provisions

1) False Statements and Kickbacks, Bribes, and Rebates

Under 42 U.S.C. §1320a-7b(a), if an individual or entity is determined to have engaged in any following activities, he or she shall be guilty of a felony and upon conviction shall be fined a maximum of $50,000 per violation or imprisoned for up to five years per violation, or both:

- Purposefully involved in supplying false information on an application for a Medicare benefit or payment or for use in determining the right to any such benefit or payment;
- Knows about, but does not disclose, any event affecting the right to receive a benefit;
- Knowingly submitting a claim for physician services that were not rendered by a physician; or
- Supplies items or services and asks for, offers, or receives a kickback, bribe, or rebate.

2) Anti-Kickback Statute

The Anti-Kickback Statute, 42 U.S.C. §1320a-7b(b), prohibits offering, soliciting, paying, or receiving remuneration for referrals for services that are paid in whole or in part by the Medicare Program. In addition, the statute prohibits offering, soliciting, paying, or receiving remuneration in return for purchasing, leasing, ordering, arranging for, or recommending the purchase, lease, or order of any goods, facility, item, or service for which payment may be made in whole or part by the Medicare Program. An arrangement will be deemed to not violate the Anti-Kickback Statute if it fully complies with the terms of a safe harbor issued by the OIG. Arrangements that do not fit within a safe harbor and thus do not qualify for automatic protection may or may not violate the Anti-Kickback Statute, depending on their facts.

3) Physician Self Referral ("Stark") Statute

The Stark Statute, 42 U.S.C. §1395nn, prohibits a physician from making a referral for certain designated health services to an entity in which the physician (or a member of his or her family) has an ownership/investment interest or with which he or she has a compensation arrangement, unless an exception applies.

Exceptions to the prohibition on self referrals can be found in the *Code of Federal Regulations (CFR)* at CFR 411.355-357. To access the *CFR*, visit www.gpoaccess.gov/cfr/index.html on the Web. The designated health services include the following:

- Clinical laboratory services;
- Physical therapy services;
- Occupational therapy services;
- Speech-language pathology services;
- Radiology and certain other imaging services such as magnetic resonance imaging and ultrasound;
- Radiation therapy services and supplies;
- Durable medical equipment and supplies;
- Parenteral and enteral nutrients, equipment, and supplies;
- Prosthetics, orthotics, and prosthetic devices and supplies;
- Home health services and supplies;
- Outpatient prescription drugs; and
- Inpatient and outpatient hospital services.

The chart below depicts some of the criminal statutes that the DOJ may invoke to pursue individuals or health care entities that have committed fraud and abuse.

Fraud and Abuse Statutes

18 U.S.C. §1347	Health care fraud
18 U.S.C. §669	Theft or embezzlement in connection with health care
18 U.S.C. §1035	False statements relating to health care
18 U.S.C. §1518	Obstruction of a Federal health care fraud investigation
18 U.S.C. §371	Conspiracy to commit fraud
18 U.S.C. §287	False claims
18 U.S.C. §1001	False statements
18 U.S.C. §§201, 666	Bribery
42 U.S.C. §§1320a - 7b	False statements, kickbacks
18 U.S.C. §§1956 - 57	Money laundering
18 U.S.C. §§1961 - 64	Racketeering Influenced and Corrupt Organizations Act
18 U.S.C. §1343	Wire fraud
18 U.S.C. §1341	Mail fraud

The DOJ or a private relator can also file a suit under the civil False Claims Act (31 U.S.C. §3729) to recover any Federal losses due to false claims as well as additional amounts in the form of penalties and fines.

Potential Legal Actions

It is a Federal crime to commit fraud against the U.S. government, including the Medicare Program. A provider, supplier, or health care organization that has been convicted of fraud may receive a significant fine, prison sentence, or be temporarily or permanently excluded from Medicare and other Federal health care programs. In some states, providers, suppliers, and health care organizations may also lose their licenses. Below is a discussion of some of the potential consequences of failure to comply with fraud and abuse laws.

Investigations

A Program Safeguard Contractor or Medicare Contractor BI unit identifies and documents potential fraud and abuse and, when appropriate, refers such matters to the OIG.

Civil Monetary Penalties

Many violations of Medicare laws and regulations are subject to the imposition of Civil Monetary Penalties (CMP). Depending on the violation, the CMP amount may be up to $10,000 per violation and exclusion from the Medicare Program may be imposed. Some examples of violations for which CMPs may apply include:

- Violation of Medicare assignment provisions;
- Violation of the Medicare physician or supplier agreement;
- False or misleading information expected to influence a decision to discharge;
- Violation of an assignment requirement for certain diagnostic clinical laboratory tests and nurse-anesthetist services;
- A supplier who refuses to supply rental durable medical equipment supplies without charge after rental payments may no longer be made;
- Violations of the Anti-Kickback Statute, Stark Statue, and other fraud and abuse laws;
- Hospital unbundling of outpatient surgery costs; and
- Hospital and physician dumping of patients, either because they cannot pay or because of a lack of resources.

Denial or Revocation of Medicare Provider Number

CMS has the authority to deny an individual or entity's application for a Medicare PIN or to revoke a Medicare PIN if there is evidence of impropriety (e.g., previous convictions, falsifying information on the application, or State or Federal licensure or certification requirements are not met).

Suspension of Payments

CMS has the authority to suspend payment to individuals and entities when there is reliable information that:

- An overpayment exists;
- Fraud exists;
- Willful misrepresentation exists; or
- Payments to be made may not be correct.

During payment suspensions, claims that are submitted will be processed and individuals and entities will be notified about claim determinations. Actual payments due are withheld and may be used to recoup amounts that were overpaid. Individuals and entities may submit written rebuttals regarding why a suspension of payment should not be imposed.

Exclusion Authority

The OIG has the authority to exclude individuals and entities from participation in all Federal health care programs, including the Medicare Program. While the exclusion remains in effect, the individual or entity will not be able to claim payment for any items or services furnished, ordered, or prescribed in any capacity to program patients. In addition, excluded individuals are not eligible for

Federally-insured loans, Federally-funded research grants, and programs administered by other Federal agencies. All types of exclusions remain in effect until the individual or entity is eligible for and reinstated by the OIG. There are two types of exclusions:

1) Mandatory exclusions

Mandatory exclusions are imposed for a minimum statutory period of five years, although aggravating and mitigating factors may justify assessment of a lengthier exclusion. Exclusions are mandated for individuals and entities who:

- Have been convicted of any type of program-related violations;
- Have been convicted of patient abuse or neglect;
- Have felony convictions related to other health care programs; or
- Have felony convictions related to certain types of controlled substance violations.

2) Permissive exclusions

The OIG may impose permissive exclusions on individuals and entities who have misdemeanor convictions that are related to:

- Health care fraud;
- Obstruction of an investigation; and
- Certain types of controlled substance violations.

These permissive exclusions typically have a benchmark period duration of three years, although aggravating and mitigating factors may justify assessment of a lengthier exclusion.

Other permissive exclusions are based on determinations made by other agencies such as licensing boards, Federal or State health care programs, and/or recommendations from payer agencies. The period of exclusion in most of these actions varies and is subject to the discretion of the OIG.

Sanctioned and Reinstated Provider and Supplier Lists

There are two types of sanctioned and reinstated provider and supplier lists:

1) Office of Inspector General

The OIG List of Excluded Individuals/Entities (LEIE) contains the following information about individuals and entities that are currently excluded from participation in all Federal health care programs, including the Medicare Program:

- Name and address;
- Date of birth;
- Specialty;
- PIN(s);
- Unique Physician/Practitioner Identification Number; and
- The exclusion authority under which the exclusion was imposed.

The LEIE is available at *www.oig.hhs.gov/fraud/exclusions/listofexcluded.html* on the Web.

2) General Services Administration

The General Services Administration Excluded Parties List System contains debarment, exclusion, and suspension lists for all Federal agencies. The Excluded Parties List System can be found at *www.epls.gov* on the Web.

Incentive Reward Program

The Incentive Reward Program encourages the reporting of information with regard to individuals or entities that commit fraud or abuse that could result in sanctions under any Federal health care program. Medicare offers a monetary reward for information that leads to a minimum recovery of $100.00 of Medicare funds that were inappropriately obtained. Incentive rewards are 10 percent of the amount recovered or $1,000, whichever amount is lower.

Whistle Blower Provision

Under the Whistle Blower or *qui tam* provision of the False Claim Act, any individual who has knowledge of a false claim may file a civil suit on behalf of the U.S. government and may share a percentage of the recovery realized from a successful action.

How to Report Suspected Fraud or Abuse

To report suspected fraud or abuse, contact either:

- OIG National Hotline
  Telephone: (800) 447-8477
- Medicare Customer Service Center
  Telephone: (800) 633-4227

To find additional information about protecting the Medicare Trust Fund, see the Medicare Program Integrity Manual (Pub. 100-8) at *www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage* on the CMS website.

CHAPTER 7

INQUIRIES, OVERPAYMENTS, AND APPEALS

This chapter discusses inquiries, overpayments, and appeals.

Inquiries

Medicare providers and suppliers may submit inquiries about claims, coverage, and reimbursement guidelines to Medicare Contractors either by telephone or in writing. Customer Service Representatives (CSR) are available to handle telephone inquiries continuously during normal business hours for all time zones of the geographic area serviced, Monday through Friday. To find Medicare Contractor contact information, visit *www.cms.hhs.gov/apps/contacts* on the Centers for Medicare & Medicaid Services (CMS) website.

Contractors also use automated self-help tools such as Interactive Voice Response (IVR) services, which may be available up to 24 hours a day. IVR services provide information about the following topics:

- Normal business hours;
- CSR service hours of operation;
- General Medicare Program;
- General appeal rights and the actions required to exercise appeal rights;
- Claims in process and claims completed; and
- Definitions of the 100 most frequently used Remittance Advice Remark Codes and/or Claim Adjustment Reason Codes, which appear on the Remittance Advice (RA) (as determined by each Contractor).

Overpayments

Overpayments are funds that a provider, supplier, or beneficiary has received in excess of amounts due and payable under Medicare statutes and regulations. Once a determination of an overpayment has been made, the amount of the overpayment becomes a debt owed to the Federal government. Federal law requires CMS to seek recovery of overpayments, regardless of how an overpayment is identified or caused.

Overpayments are often paid due to the following:

- Duplicate submission of the same service or claim;
- Payment to the incorrect payee;
- Payment for excluded or medically unnecessary services; or
- Payment made as the primary insurer when Medicare should have paid as the secondary insurer.

If Medicare pays more than the correct amount in error, providers and suppliers should make voluntary refunds as soon as possible, without waiting for notification. A notification called a demand letter is sent when an overpayment occurs, which states:

- The service(s) at issue;
- Why the overpayment occurred; and
- The amount being requested.

Refunds are sent to the Medicare Contractor and must include the following information:

- The Provider Identification Number (PIN) and the PIN of the provider who should actually be paid, if applicable;
- The Medicare Health Insurance Claim (HIC) number;
- The date of service;
- The amount overpaid;
- A brief description regarding the reason for the refund;
- A copy of the RA; and
- A check for the overpaid amount.

If the overpayment is not paid in full within 30 days of the date of the first demand letter, interest begins to accrue on day 31. When the Federal government accepts a voluntary refund, it does not affect or limit its right or the right of its agencies or agents to pursue any appropriate criminal, civil, or administrative remedies that arise from or related to applicable claims.

If a provider or supplier disagrees with the overpayment, he or she has the right to appeal the decision. Recoupment will cease if:

- The first recoupment action occurred after December 8, 2003; or
- A first level appeal has been received.

To find additional information about overpayments, see the Medicare Claims Processing Manual (Pub. 100-04) located at *www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage* on the CMS website.

Fee-for-Service Appeals

An appeal is an independent review of an initial determination made by a Medicare Contractor. Generally, a party to the initial determination is entitled to an appeal if he or she is dissatisfied with the determination and files a timely appeal request that contains the necessary information needed to process the request.

A party to an initial determination may be:

- A beneficiary who files a request for payment or has a request for payment filed on his or her behalf by a provider;
- A supplier who has accepted assignment for items or services furnished to a beneficiary that are at issue in the request for payment; or
- A provider of services who files a request for payment for items or services furnished to a beneficiary.

A party to a higher level appeal may be:

- The parties to an initial determination, except when a beneficiary has assigned his or her appeal rights;
- A State agency pursuant to the *Code of Federal Regulations (CFR)* at 42 CFR 405.908 (to access the *CFR*, visit *www.gpoaccess.gov/cfr/index.html* on the Web);
- A provider or supplier who accepts assignment of appeal rights for items or services furnished to a beneficiary; or
- A nonparticipating physician or supplier who does not accept assignment for items or services furnished to a beneficiary and may be obligated to make a refund pursuant to §§1834(a)(18), 1834(j)(4), or 1842(l) of the Social Security Act.

A provider or supplier who is not already a party to an appeal may appeal an initial determination for services furnished to a beneficiary if the beneficiary subsequently dies leaving no other party available to appeal the determination.

A party may appoint a representative if he or she wants assistance with their appeal. A physician or supplier may act as a beneficiary's appointed representative. A party may appoint a representative to act on his or her behalf by completing Form CMS-1696, Appointment of Representative (AOR), which is available at *www.cms.hhs.gov/CMSForms/CMSForms/list.asp#TopOfPage* on the CMS website. A party may also appoint a representative through a submission that meets the following requirements:

- It is in writing and is signed and dated by both the party and the individual who is agreeing to be the representative;
- It includes a statement appointing the representative to act on behalf of the party and if the party is a beneficiary, authorizing the adjudicator to release identifiable health information to the appointed representative;
- It includes a written explanation of the purpose and scope of the representation;
- It contains the name, telephone number, and address of both the party and the appointed representative;
- If the party is a beneficiary, the beneficiary's Medicare HIC number;

- It indicates the appointed representative's professional status or relationship to the party; and
- It is filed with the entity that is processing the party's initial determination or appeal.

A representative may submit arguments, evidence, or other materials on behalf of the party. The representative, the party, or both may participate in all levels of the appeals process. Once both the party and the representative have signed the AOR Form, the appointment is valid for one year from the date of the last signature for the purpose of filing future appeals unless it has been revoked.

As noted above, a beneficiary may also assign (transfer) his or her appeal rights to a physician or supplier who is not a party to the initial determination and who furnished the items or services at issue in the appeal. A beneficiary must assign appeal rights using the form CMS-20031, Transfer of Appeal Rights, available at *www.cms.hhs.gov/CMSForms/CMSForms/list.asp#TopOfPage* on the CMS website. A physician or supplier who accepts assignment of appeal rights must waive the right to collect payment from the beneficiary for the items or services at issue in the appeal, with the exception of deductible and coinsurance amounts and when a valid Advance Beneficiary Notice is in effect.

After an initial claim determination is made, the appeals process is as follows:

- Redetermination by Medicare Contractor;
- Reconsideration by Qualified Independent Contractor (QIC);
- Hearing by Administrative Law Judge (ALJ);
- De Novo Review by Medicare Appeals Council (MAC); and
- Judicial Review.

First Level of Appeal – Redetermination by Medicare Contractor

A party who is dissatisfied with the initial determination may request that a Medicare Contractor conduct a redetermination. The redetermination, which is an independent review of the initial determination, is conducted by an employee of the Contractor who was not involved in making the initial determination. A request for a redetermination must be filed within 120 calendar days of the date the notice of initial claim determination is received. If good cause is shown, the period for filing the appeal request may be extended. At this level of appeal, there is no amount in controversy (AIC) requirement. When filing the request for redetermination, parties should also submit all relevant documentation to support their assertion that the initial claim determination was incorrect.

Parties must request redeterminations in writing by either completing Form CMS-20027, Medicare Redetermination Request, which is available at www.cms.hhs.gov/CMSForms/CMSForms/list.asp#TopOfPage on the CMS website or by submitting a written request that includes the following:

- Beneficiary's name;
- Beneficiary's Medicare HIC number;
- Which items or services are at issue and the corresponding date(s) of service; and
- Name and signature of the party or representative of the party.

In most cases, the Contractor will issue a written redetermination notice to all parties to the appeal within 60 days of receipt of the redetermination request. If the reconsideration results in the issuance of a supplemental payment to a provider or supplier, the Contractor must also issue an electronic or paper RA.

Second Level of Appeal – Reconsideration by QIC

A party dissatisfied with the redetermination decision may request a reconsideration by a QIC. For all redeterminations issued on or after January 1, 2006, the reconsideration by the QIC replaces the Hearing Officer Hearing previously conducted by Medicare Part B Contractors. Appeals of redeterminations issued prior to January 1, 2006 will be conducted by hearing officers.

A party must file a written request for a reconsideration with the entity specified in the redetermination notice within 180 calendar days of the date the redetermination decision is received. If good cause is shown, the QIC may extend the period for filing the request. At this level of appeal, there is no AIC requirement. A party may file a written request for reconsideration by either completing Form CMS-20033, Medicare Reconsideration Request, which is available at www.cms.hhs.gov/CMSForms/CMSForms/list.asp#TopOfPage on the CMS website or by submitting a written request that includes the following:

- Beneficiary's name;
- Beneficiary's Medicare HIC number;
- Which items or services are at issue and the corresponding date(s) of service;
- Name and signature of the party or representative of the party; and
- Name of the Contractor that made the redetermination.

For appeals of redeterminations issued prior to January 1, 2006, parties may file a written request for a Hearing Officer Hearing by either completing Form CMS-1965, Request for Hearing, which is available at www.cms.hhs.gov/CMSForms/CMSForms/list.asp#TopOfPage on the CMS

website or by submitting a written request that includes the information described above. Hearing officers generally issue decision letters within 120 days of receipt of the hearing request.

In most cases, the QIC will issue written notice of its reconsideration decision to all parties within 60 calendar days of receipt of the request for reconsideration. In some situations (e.g., submission of additional evidence after the reconsideration request is filed), the time limit will be extended beyond 60 days. If the QIC is unable to issue a reconsideration within the applicable time limit, the QIC will notify the appellant (the party who filed the appeal request). The appellant may then file a written request with the QIC to escalate the appeal to the Administrative Law Judge (ALJ) level. Within five days of receiving the request to escalate, the QIC will either issue a reconsideration or acknowledge the escalation request and forward the request and case file to the appropriate ALJ office. If the reconsideration results in the issuance of a supplemental payment to a provider or supplier, the Contractor must also issue an electronic or paper RA. All evidence requested by the Contractor in the redetermination decision must be submitted at the QIC reconsideration level of appeal. Failure to submit requested information at the QIC reconsideration level may lead to exclusion of such evidence at subsequent levels of appeal.

Third Level of Appeal – Hearing by ALJ

If a party is dissatisfied with the reconsideration decision (or Part B hearing officer decision) or if the adjudication period for the QIC to complete its consideration has elapsed, he or she can request a hearing before an ALJ with the Department of Health and Human Services (HHS) Office of Medicare Hearings and Appeals. There is an AIC requirement, which will be adjusted annually in accordance with the percentage increase in the medical care component of the Consumer Price Index (CPI). The ALJ hearing may be conducted in person, via video teleconferencing (VTC) technology, or by telephone. The ALJ may also issue a decision on the record without the appearance of any parties if the decision is fully favorable to the appellant. In person hearings may be granted upon a finding of good cause. An ALJ may also determine that an in person hearing should be conducted if VTC technology is unavailable or special or unusual circumstances exist.

A party must file a written request for an ALJ hearing with the entity specified in the QIC reconsideration notice (or Part B hearing officer decision letter) within 60 calendar days of receipt of the QIC reconsideration notice or Part B hearing officer decision letter. If a request for an ALJ hearing is not filed timely, the period for filing the request may be extended by the ALJ if good cause is shown.

During the transition from Part B hearing officer decisions to QIC reconsiderations, there will be two different forms that may be used to request an ALJ hearing. If a party is filing a request for an ALJ hearing to appeal a QIC reconsideration, he or she may either complete Form CMS-20034A/B, Request For Medicare Hearing By An Administrative Law Judge, which is available at *www.cms.hhs.gov/CMSForms/CMSForms/list.asp#TopOfPage* on the CMS website or submit a written request that includes the following information:

- Name, address, and Medicare HIC number of the beneficiary whose claim is being appealed;
- Name and address of the appellant, when the appellant is not the beneficiary;
- Name and address of any designated representatives;
- Document control number assigned to the appeal by the QIC, if any;
- Dates of service for the items or services at issue;
- Reasons the appellant disagrees with the QIC's reconsideration (or Part B hearing officer decision); and
- Statement of any additional evidence to be submitted and the date it will be submitted.

If a party is filing a request for an ALJ hearing to appeal a hearing officer decision, he or she may either complete Form CMS-5011A/B, Request For Medicare Hearing By An Administrative Law Judge, which is available at *www.cms.hhs.gov/CMSForms/CMSForms/list.asp#TopOfPage* on the CMS website or submit a written request that includes the information noted in the paragraph above regarding how to request an ALJ hearing to appeal a QIC reconsideration.

When an appellant requests an ALJ hearing following a QIC reconsideration, the appellant must also send a copy of the request for hearing to the other parties to the appeal. The ALJ's 90-day timeframe to issue a decision does not start until all parties to the QIC reconsideration receive notice of the requested ALJ hearing.

Generally, at the ALJ level, CMS and/or CMS Contractors may elect to either participate in the hearing or become a party to the hearing. If CMS and/or CMS Contractors choose to participate or become a party to the hearing, it will notify the ALJ and all parties within 10 days after receiving the notice of hearing. Participating in the hearing or as a party may include submitting position papers or providing testimony to clarify factual or policy issues, but does not include calling or cross-examining witnesses or being called as a witness. In addition, discovery is allowed only when CMS becomes a party to an ALJ hearing.

In most cases, the ALJ will issue a decision within 90 days of receipt of the request for hearing. The time limit may be extended (for example, if a party issues a discovery request in cases where CMS is a party). If the case before the ALJ was escalated from the QIC, the ALJ must issue a decision in 180 days (unless the time limit was extended for the reasons noted above). If the decision results in the issuance of a supplemental payment to a provider or supplier, the Contractor must also issue an electronic or paper RA. If an ALJ case is still pending at the close of the applicable adjudication timeframe, the appellant may file a written request with the ALJ and the MAC to escalate the appeal to the MAC. The appellant must notify all parties to the ALJ hearing about the escalation request. Failure to send notice to all parties will toll or stop the adjudication timeframes for the MAC to conduct its review.

Fourth Level of Appeal – De Novo Review by MAC

The appellant or any other party to the ALJ hearing may request MAC review of the ALJ's decision or dismissal. The request for MAC review must be filed within 60 calendar days of receipt of the ALJ hearing decision or dismissal. If good cause is shown, the period for filing the request may be extended. At this level of appeal, there is no AIC requirement.

The party must file a written request for MAC review by either completing Form DAB-101, Request for Review of Administrative Law Judge Medicare Decision/Dismissal, which is available at *www.hhs.gov/dab/DAB101.pdf* on the HHS website or submitting a written request that includes the following:

- Beneficiary's name;
- Beneficiary's Medicare HIC number;
- Specific items or services for which review is requested;
- Dates of service for the items or services at issue;
- Date of the ALJ's final action (if any) or the hearing office in which the party's request for hearing is pending; and
- Name and signature of the party or representative of the party.

The request for MAC review must also identify the parts of the ALJ action with which the party requesting review disagrees and explain why he or she disagrees with the ALJ's decision, dismissal, or other determination being appealed. The MAC will generally limit its review to the issues raised by the appellant and will conduct a *de novo* or new review of such issues.

The appellant must also send a copy of the request for review to the other parties to the ALJ decision or dismissal. The time limit for issuance of the MAC decision (discussed below) does not commence until all parties are properly notified.

Generally, the party requesting the MAC review does not have a right to a hearing before the MAC. The MAC will consider all of the evidence in the administrative record and either adopt, modify, or reverse the ALJ decision or remand the case to the ALJ for further proceedings. However, depending on how the appeal came before the MAC, there may be opportunities for parties to submit additional evidence. Parties to MAC review may request the opportunity to file briefs or other written statements discussing the facts and laws relevant to the case. A party may also request to appear before the MAC to present oral argument. The MAC may also dismiss a review request if the party making the request asks to withdraw the request for MAC review, does not have a right to request MAC review, or in certain circumstances where the beneficiary whose claim is being appealed dies.

In most cases, the MAC decision, dismissal, or remand order will be mailed within 90 calendar days of submission of the request. If the decision results in the issuance of a supplemental payment to a provider or supplier, the Medicare Contractor must also issue an electronic or paper RA. If the case was escalated to the MAC because the ALJ could not issue a timely decision, the MAC will have 180 days to mail its decision. These timeframes may be extended under certain circumstances (for example, if a party filing a request for review fails to provide copies of the request for review to other parties to the ALJ decision or dismissal). If the MAC fails to issue a decision, dismissal, or remand order within the applicable time period, the appellant may submit a request for escalation to Federal District Court. The MAC will either complete the case within five days of receipt of the escalation request or within five days following the end of the applicable adjudication timeframe. If the MAC is unable to complete the case, it will issue a notice to the appellant that acknowledges the escalation request and confirms its inability to issue a decision, dismissal, or remand order within the applicable timeframe. A party may then file a civil action in Federal District Court within 60 days after the date it receives notice from the MAC. In certain instances, if good cause is shows, the period for filing the request may be extended. Escalation is not available with regard to a request to review an ALJ dismissal.

Fifth Level of Appeal – Judicial Review

A party to a MAC decision or an appellant who requests an escalation of a MAC review may obtain judicial review if the case meets the AIC requirement. For actions filed on or after January 1, 2006, the AIC will be $1,090. The AIC amount is adjusted annually in accordance with the percentage increase in the medical care component of the CPI.

Any civil action for judicial review must be filed in the District Court of the U.S. for the judicial district in which the party resides or where such individual, institution, or agency has its principal place of business. If the party does not reside within

any judicial district or if the individual, institution, or agency does not have its principal place of business within any such judicial district, the civil action must be filed in the District Court of the U.S. for the District of Columbia. The Secretary of HHS is the proper defendant in any request for judicial review of a MAC decision or a case escalated to Federal District Court.

Complaints filed in Federal District Court against the Secretary of HHS should also be sent to:

Department of Health and Human Services
General Counsel
200 Independence Avenue, S.W.
Washington, D.C. 20201

The District Court may either reach a final decision or remand the case to the MAC or ALJ for further proceedings. Written notification regarding the District Court's decision is sent to all the parties.

Liability and Appeal Decisions

Liability regarding appeal decisions is as follows:

- When an original claim determination for both assigned and nonassigned claims is upheld on a review and the provider or supplier knew or could have been expected to know that payment for the service might be denied or reduced, he or she is held liable and must refund any monies collected from the beneficiary within 30 days of the review decision.
- When an original claim determination for an assigned claim is upheld on a review and the provider or supplier and beneficiary could not have been expected to know that payment for the service might be denied or reduced, payment is made to the provider or supplier.
- When an original claim determination for a nonassigned claim is upheld on a review and it is found that the provider or supplier could not have been expected to know that payment for the service might be denied or reduced, he or she is notified that payment may be collected from the beneficiary. A letter is sent to the beneficiary indicating that he or she is responsible for payment.

- When the beneficiary is not responsible for the payment of a service, the provider or supplier must refund any monies collected from the beneficiary. If the refund is not made within the specified time limits, the following actions may occur:
    - For an assigned claim, the beneficiary may submit a request to Medicare for indemnification from payment. A letter is sent to the provider or supplier indicating that a refund must be made to the beneficiary within 15 days for the amount actually paid, including any amounts applied to deductibles, coinsurance, and copayments. If the refund is not made within 15 days, Medicare will pay the beneficiary and request a refund from the provider or supplier.
    - For a nonassigned claim, the beneficiary may notify Medicare that the provider or supplier did not refund the amount due. A letter is sent to the provider or supplier indicating that a refund is due to the beneficiary within 15 days. If a refund is not made within 15 days, the provider or supplier may be subject to Civil Monetary Penalties and sanctions.

Reopening

A reopening is a remedial action taken to change a final determination or decision that resulted in either an overpayment or underpayment, even though the determination or decision was correct based on the evidence of record. A reopening allows the correction of minor errors or omissions without initiating a formal appeal. If a claim is denied because a Contractor did not receive requested documentation during medical review and the party later requests a redetermination, the Contractor must process the request as a reopening. A Contractor must also process clerical errors (including human and mechanical errors on the part of the party or Contractor) such as mathematical or computational mistakes, inaccurate data entry, or denials of claims as duplicates. A reopening is, in general, not conducted until a party's appeal rights have been exhausted. A Contractor, QIC, ALJ, or MAC's decision on whether to reopen is final and not subject to appeal. A reopening may be requested by a party or initiated by a Contractor, QIC, ALJ, or MAC.

The timeframes and requirements for requesting or initiating a reopening will depend on the level at which the reopening is requested (initial determination level or one of the appeals levels) and who is initiating the reopening (a party, Contractor, QIC, ALJ, or MAC). When any determination or decision is reopened and revised, a Contractor, QIC, ALJ, or MAC must mail its revised determination or decision to the parties. If the reopening action results in an adverse revised determination or decision, the Contractor shall mail a letter that states the rationale for the reopening, the applicable revision, and any right to appeal.

To find additional information about appeals, see the Medicare Claims Processing Manual (Pub. 10-4) at *www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage* on the CMS website.

REFERENCE SECTION

REFERENCE A
GLOSSARY

A

Abuse
May be intentional or unintentional; directly or indirectly results in unnecessary or increased costs to the Medicare Program.

Advance Beneficiary Notice
A written notice that a provider or supplier gives to a beneficiary before items or services are furnished to advise him or her that specified items or services may not be covered by Medicare.

Aged Insured
A beneficiary who is at least 65 years old and eligible for Social Security, Railroad Retirement, or equivalent Federal benefits. For Medicare purposes, beneficiaries attain age 65 the day before their actual 65th birthday.

Appeal
An independent review of an initial determination made by a Medicare Contractor.

Assignment
When a provider or supplier is paid the Medicare allowed amount as payment in full for his or her services.

B

Balanced Budget Act of 1997
Law that amended Sections of the Social Security Act to include anti-fraud and abuse provisions, program integrity, and preventive care benefits and established the State Children's Health Insurance Program and the Medicare + Choice Program (now known as Medicare Advantage or Part C of the Medicare Program).

Beneficiary
An individual who has health insurance through the Medicare Program.

Benefits Improvement and Protection Act of 2000
Law that amended Titles XVIII, XIX and XXI of the Social Security Act to provide benefits improvements and beneficiary protections in the Medicare, Medicaid, and State Children's Health Insurance Programs.

C

Carrier
Contractor for the Centers for Medicare & Medicaid Services that determines reasonable charges, accuracy, and coverage for Medicare Part B services and processes Part B claims and payments (see Medicare Administrative Contractor).

Centers for Medicare & Medicaid Services
An Agency within the U.S. Department of Health and Human Services that administers and oversees the Medicare, Medicaid, and State Children's Health Insurance Programs and awards contracts to Contractors who perform claims processing and related administrative functions.

Certificate of Medical Necessity
Form that is included with claims for certain items that require additional information (e.g., durable medical equipment and parenteral and enteral nutrition).

Claim
A filing from a provider, supplier, or beneficiary that includes a request for Medicare payment and furnishes the Medicare Contractor with sufficient information to determine whether payment of benefits is due and the amount of payment.

Code of Federal Regulations
Official compilation of Federal rules and requirements.

Coinsurance
Percent of the Medicare-approved amount that a beneficiary pays after he or she pays the plan deductible.

Comprehensive Error Rate Testing
Program that measures and improves the quality and accuracy of Medicare claims submission, processing, and payment.

Consultation
Primarily performed at the request of a referring physician or practitioner in order to provide him or her with advice or an opinion.

Coordination of Benefits
The process that determines the respective responsibilities of two or more health plans that have some financial responsibility for a medical claim.

Copayment
In some Medicare health plans, the fixed amount that is paid by the beneficiary for each medical service.

Cost Report
Report required from providers on an annual basis in order to make a proper determination of amounts payable under the Medicare Program.

Covered Service
Reasonable and necessary service furnished to Medicare patients that are reimbursable to the provider, supplier, or beneficiary.

Critical Access Hospital
Hospital that is located in a state that has established a State Medicare Rural Hospital Flexibility Program, is located in a rural area or treated as rural under a special provision that allows hospitals in urban areas to be treated as rural for purposes of becoming a Critical Access Hospital (CAH), provides 24-hour emergency care services using either on-site or on-call staff, provides no more than 25 inpatient beds, has an average length of stay of 96 hours or less and is either more than 35 miles from a hospital or another CAH or more than 15 miles in areas with mountainous terrain or only secondary roads OR certified by the state as of December 31, 2005 as being a "necessary provider" of health care services to residents in the area.

D

Deductible
Amount a beneficiary must pay for health care each calendar year before Medicare begins to pay, either for each benefit period for Part A or each year for Part B.

Department of Health and Human Services
Administers many Federal health and welfare programs for citizens of the U.S. and is the parent agency of the Centers for Medicare & Medicaid Services.

Disabled Insured
Insured beneficiary who is automatically entitled to Medicare Part A after receiving Social Security disability cash benefits for 24 months and is enrolled in Medicare Part B unless he or she refuses Part B coverage.

Durable Medical Equipment
Medical equipment ordered by a physician or, if Medicare allows, a nurse practitioner, physician assistant or clinical nurse specialist for use in the home. The item must be reusable (e.g., walkers, wheelchairs, or hospital beds).

E

End-Stage Renal Disease Insured
Insured beneficiary of any age who in order to maintain life receives regular dialysis treatments or a kidney transplant, has filed an application, and meets one of the following: certain work requirements for Social Security insured status or entitled to monthly Social Security benefits, eligible under Railroad Retirement Programs or entitled to an annuity under the Railroad Retirement Act, or is the spouse or dependent child of an insured individual.

F

Fiscal Intermediary
Contractor for the Centers for Medicare & Medicaid Services that processes claims for services covered under Medicare Part A and most types of claims for services covered under Medicare Part B (see Medicare Administrative Contractor).

Fraud
Generally involves a person or entity's intentional use of false statements or fraudulent schemes (such as kickbacks) to obtain payment for, or to cause another to obtain payment for, items or services payable under a Federal Health care program.

H

Healthcare Common Procedure Coding System
Uniform method for providers and suppliers to report professional services, procedures, and supplies and includes Current Procedural Terminology codes and national alphanumeric codes.

Health Professional Shortage Area
Geographic areas that have been designated as primary medical care health professional shortage areas by the Health Resources and Services Administration.

Hospice
Part A coverage for the terminally ill for the terminally ill beneficiary who meets all the following conditions: eligible for Part A, certified as having a terminal disease with a prognosis of six months or less if the illness runs its normal course, receives care from a Medicare-approved hospice program, and signs a statement which states he or she elects the hospice benefit and waives all rights to Medicare payments for services for the terminal illness and related conditions (Medicare will continue to pay for covered benefits that are not related to his or her terminal illness).

I

Incentive Payment
Payments paid to physicians who furnish medical care in geographic areas that have been designated as primary medical care Health Professional Shortage Areas or Physician Scarcity Areas.

Incentive Reward Program
Encourages the reporting of information regarding individuals or entities that commit fraud or abuse that could result in sanctions under any Federal health care program.

Incident To
Services that are commonly furnished in physicians' offices or clinics, furnished by the physician or auxiliary personnel under the direct personal supervision of a physician, commonly furnished without charge or included in the physician's bill, and are an integral, although incidental, part of the physician's professional service.

L

Local Coverage Determination; formerly known as Local Medical Review Policies
In the absence of a National Coverage Determination, a coverage decision made at a local Medicare Contractor's own discretion to provide guidance to the public and the medical community within a specified geographic area; outline coverage criteria, define medical necessity, provide codes that describe what is and is not covered when the codes are integral to the discussion of medical necessity, and provide references upon which a policy is based.

M

Medicaid
A cooperative venture funded by Federal and State governments that pays for medical assistance for certain individuals and families with low incomes and limited resources.

Medically Necessary
Services or supplies that are proper and needed for diagnosis or treatment of the patient's medical condition; furnished for the diagnosis, direct care, and treatment of the patient's medical condition; meet standards of good medical practice; and are not mainly for the convenience of the patient, provider, or supplier.

Medical Review
Review of claims appropriately submitted to Medicare Contractors when atypical billing patterns or particular kinds of problems (e.g., errors in billing a specific type of service) are identified.

Medicare Administrative Contractor
As mandated by Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, new single authorities that Fiscal Intermediaries and Carriers will be integrated into beginning in 2006.

Medicare Physician Fee Schedule
Establishes Medicare payment policies and rates for over 10,000 procedures performed by providers, physicians, and certain nonphysician practitioners (e.g., nurse practitioners, physician assistants, and physical therapists).

Medicare Prescription Drug, Improvement, and Modernization Act of 2003
Comprehensive bill signed by President George W. Bush on December 8, 2003 to expand many parts of the Medicare Program.

Medicare Summary Notice
Notice that beneficiaries receive on a monthly basis; lists all services or supplies that were billed to Medicare.

Medigap
A health insurance policy sold by private insurance companies to fill gaps in Original Medicare Plan coverage.

N

National Correct Coding Initiative
Initiative that promotes correct coding by providers and suppliers and ensures that appropriate payments are made for the services they furnish.

National Coverage Determination
Sets forth the extent to which Medicare will cover specific services, procedures, or technologies on a national basis.

National Provider Identifier
Identifier that all Health Insurance Portability and Accountability Act (HIPAA) covered entities (including Medicare, Medicaid, private health plans, and all health care clearinghouses) must use to identify HIPAA-covered health providers in standard transactions by May 23, 2007. Small health plans must use by May 23, 2008.

Notice of Exclusions from Medicare Benefits
Notice that advises the beneficiary in advance that Medicare will not pay for certain items and services that do not meet the definition of a Medicare benefit or are specifically excluded by law.

O

Office of Inspector General
Protects the integrity of Department of Health and Human Services programs and the health and welfare of beneficiaries of those programs through a nationwide network of audits, investigations, inspections, and other mission-related functions.

Overpayment
Funds that a provider, supplier. or beneficiary has received in excess of amounts due and payable under Medicare statutes and regulations.

P

Part A of the Medicare Program
Hospital insurance that pays for inpatient hospital stays, inpatient care in a Skilled Nursing Facility following a covered hospital stay, hospice care, and some home health care.

Part B of the Medicare Program
Medical insurance that helps pay for medically necessary services furnished by physicians, home health care, ambulance services, clinical laboratory and diagnostic services, surgical supplies, durable medical equipment and supplies, and services furnished by practitioners with limited licensing.

Part C of the Medicare Program; Medicare Advantage; formerly known as Medicare + Choice
Organizations that contract with the Centers for Medicare & Medicaid Services provide or arrange for the provision of health care services to Medicare beneficiaries who are entitled to Part A and enrolled in Part B, permanently reside in the service area of the Medicare Advantage (MA) Plan, and elect to enroll in a MA Plan.

Part D of the Medicare Program
Prescription drug coverage available to all beneficiaries who elect to enroll in a prescription drug plan beginning on January 1, 2006.

Participating Provider or Supplier
When a provider or supplier participates in the Medicare Program and accepts assignment of benefits for all covered services for all Medicare patients.

Physician (Medicare)
Doctors of medicine and doctors of osteopathy, doctors of dental surgery or dental medicine, chiropractors, doctors of podiatry or surgical chiropody, and doctors of optometry. Must also be legally authorized to practice by a state in which he or she performs this function.

Physician Scarcity Area
U.S. county with a low ratio of primary care or specialty physicians to Medicare beneficiaries.

Practitioner (Medicare)
Any of the following to the extent that he or she is legally authorized to practice by the state and otherwise meets Medicare requirements: physician assistant, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse midwife, clinical psychologist, clinical social worker, or registered dietician or nutrition professional.

Prospective Payment System
Method of reimbursement in which Medicare payment is made based on a predetermined, fixed amount.

Provider Identification Number; Individual Billing Number
Identifies who furnished the service to the beneficiary on the Medicare claim form, allows providers and beneficiaries to receive payment for claims filed to the Medicare Contractor, required on all claims submitted to the Contractor, and issued by the Contractor.

Q

Quality Improvement Organization; formerly known as Peer Review Organization
Organization that contracts with the Centers for Medicare & Medicaid Services to conduct quality improvement projects, promote the use of publicly-reported performance data, conduct outreach to beneficiaries and health care providers and suppliers, respond to written complaints from Medicare beneficiaries or their representatives about the quality of services for which Medicare payment may be made, monitor payment errors to reduce fraud and abuse, and ensure that patient rights are protected.

R

Remittance Advice
A notice of payments and adjustments that is sent to the provider, supplier, or biller.

Reopening
A remedial action taken to change a final determination or decision that resulted in either an overpayment or underpayment, even though the determination or decision was correct based on the evidence of record; allows the correction of minor errors or omissions without initiating a formal appeal.

S

Skilled Nursing Facility
Facility that meets specific regulatory certification requirements and primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services; does not provide the level of care or treatment available in a hospital.

Social Security Act
Public Law 74-271 that was enacted on August 14, 1935, with subsequent amendments.

Social Security Administration
Determines eligibility for Medicare benefits and enrolls individuals in Part A and/or B and the Federal Black Lung Benefit Program.

Swing Bed
Beds in small rural hospitals that can be used for either Skilled Nursing Facility or hospital acute-level care on an as-needed basis if the hospital has obtained approval from the Department of Health and Human Services.

U

Unique Physician/Practitioner Identification Number; Individual Identification Number
A national number that is used to identify physicians/practitioners who order or refer services; required for consultations, radiology services, and laboratory and diagnostic tests; a permanent number that may be used in any state where physicians/practitioners practice; received by all physicians/practitioners enrolled in the Medicare Program who order or refer beneficiary services even though they may never bill Medicare directly; received by individual physicians/practitioners (one number is assigned regardless of the number of practice settings); and assigned by the Centers for Medicare & Medicaid Services.

REFERENCE B
ACRONYMS

ABN	Advance Beneficiary Notice
ADA	American Diabetes Association
AEP	Annual Coordinated Election Period
AIC	Amount in Controversy
AIDS	Acquired Immunodeficiency Syndrome
ALJ	Administrative Law Judge
AOR	Appointment of Representative
ASC	Ambulatory Surgical Center
BBA	Balanced Budget Act of 1997
BI	Benefit Integrity
CAH	Critical Access Hospital
CC	Chief Complaint
CERT	Comprehensive Error Rate Testing
CFR	Code of Federal Regulations
CMN	Certificate of Medical Necessity
CMS	Centers for Medicare & Medicaid Services
CNM	Certified Nurse Midwife
CNS	Certified Nurse Specialist
COB	Coordination of Benefits
CP	Clinical Psychologist

CPI	Consumer Price Index
CPT	Current Procedural Terminology
CRNA	Certified Registered Nurse Anesthetist
CSR	Customer Service Representative
CSW	Clinical Social Worker
CWF	Common Working File
DES	Diethylstilbestrol
DME	Durable Medical Equipment
DMEPOS	Durable Medical Equipment, Prosthetics, Orthotics, and Supplies
DOJ	Department of Justice
DRE	Digital Rectal Exam
DSMT	Diabetes Self-Management Training
EDI	Electronic Data Interchange
E/M	Evaluation and Management
EMC	Electronic Media Claims
ESRD	End-Stage Renal Disease
FDA	Food and Drug Administration
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
GHP	Group Health Plan
GME	Graduate Medical Education
HBV	Hepatitis B Virus

HCPCS	Healthcare Common Procedure Coding System
HHS	Department of Health and Human Services
HIC	Health Insurance Claim
HIPAA	Health Insurance Portability and Accountability Act
HIV	Human Immunodeficiency Virus
HPI	History of Present Illness
HPSA	Health Professional Shortage Area
HPV	Human Papillomavirus
HRSA	Health Resources and Services Administration
ICD	International Classification of Diseases
ICEP	Initial Coverage Election Period
IEP	Initial Enrollment Period
IHS	Indian Health Service
IPPE	Initial Preventive Physical Examination
IVR	Interactive Voice Response
LCD	Local Coverage Determination
LEIE	List of Excluded Individuals/Entities
LGHP	Large Group Health Plan
MA	Medicare Advantage
MAC	Medicare Administrative Contractor Medicare Appeals Council
MIP	Medicare Integrity Program
MLN	Medicare Learning Network

MMA	Medicare Prescription Drug, Improvement, and Modernization Act of 2003
MNT	Medical Nutrition Therapy
MPFS	Medicare Physician Fee Schedule
MR	Medical Review
MSN	Medicare Summary Notice
MSP	Medicare Secondary Payer
NCCI	National Correct Coding Initiative
NCD	National Coverage Determination
NEMB	Notice of Exclusion from Medicare Benefits
NP	Nurse Practitioner
NPI	National Provider Identifier
NPP	Nonphysician Practitioner
OEP	Open Enrollment Period
OIG	Office of Inspector General
OT	Occupational Therapy
PA	Physician Assistant
PEN	Parenteral and Enteral Nutrition
PFFS	Private Fee-for-Service
PFSH	Past, Family, and/or Social History
PIN	Provider Identification Number
PPO	Preferred Provider Organization
PPS	Prospective Payment System

PPV	Pneumococcal Polysaccharide Vaccine
PSA	Physician Scarcity Area Prostate Specific Antigen
PT	Physical Therapist Physical Therapy
QDWI	Qualified Disabled and Working Individual
QIC	Qualified Independent Contractor
QIO	Quality Improvement Organization
QMB	Qualified Medicare Beneficiary
RA	Remittance Advice
ROS	Review of Systems
RRB	Railroad Retirement Board
RVU	Relative Value Unit
SA	State Agency
SEP	Special Enrollment Period
SHIP	State Health Insurance Program
SLP	Speech-Language Pathology
SNF	Skilled Nursing Facility
SSI	Supplemental Security Income
SSN	Social Security Number
TrOOP	True Out-of-Pocket
UMWA	United Mine Workers of America
UPIN	Unique Physician/Practitioner Identification Number

VHA	Veterans Health Administration
VTC	Video Teleconferencing
WC	Workers Compensation
WHO	World Health Organization

REFERENCE C
HELPFUL WEBSITES

Centers for Medicare & Medicaid Services' Websites

Ambulance Services Provider Center
www.cms.hhs.gov/center/ambulance.asp

Anesthesiologists Provider Center
www.cms.hhs.gov/center/anesth.asp

Beneficiary Notices Initiative
www.cms.hhs.gov/BNI

CMS Contact Information Directory
www.cms.hhs.gov/apps/contacts

CMS Forms
www.cms.hhs.gov/CMSForms/CMSForms/list.asp#TopOfPage

CMS Mailing Lists
www.cms.hhs.gov/apps/mailinglists

Comprehensive Error Rate Testing
www.cms.hhs.gov/CERT

Documentation Guidelines for E & M Services
www.cms.hhs.gov/MLNEdWebGuide/25_EMDOC.asp#TopOfPage

Electronic Billing and EDI Transactions
www.cms.hhs.gov/ElectronicBillingEDITrans/01_Overview.asp#TopOfPage

HPSA/PSA (Physician Bonuses)
www.cms.hhs.gov/HPSAPSAPhysicianBonuses

Health Insurance Portability and Accountability (HIPAA)
General Information
www.cms.hhs.gov/HIPAAGenInfo

Home Health Agency Provider Center
www.cms.hhs.gov/center/hha.asp

Hospice Provider Center
www.cms.hhs.gov/center/hospice.asp

Hospital Provider Center
www.cms.hhs.gov/center/hospital.asp

Internet-Only Manuals
www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage

MLN Matters Articles
www.cms.hhs.gov/MLNMattersArticles
National articles designed to inform the physician, provider, and supplier community about the latest changes to the Medicare Program. Articles are prepared in consultation with clinicians, billing experts, and CMS subject matter experts and are tailored in content and language to the specific provider type(s) who are affected by a particular Medicare change.

Medicare
The Official U.S. Government Site for People with Medicare
www.medicare.gov

Medicare Advantage
General Information
www.cms.hhs.gov/MedicareAdvantageGenInfo

Medicare Contracting Reform
www.cms.hhs.gov/MedicareContractingReform

Medicare Coverage Center
www.cms.hhs.gov/center/coverage.asp

Medicare Coverage Database
www.cms.hhs.gov/mcd/search.asp?

Medicare Fee-for-Service Provider Resource Center
www.cms.hhs.gov/center/provider.asp

Medicare Learning Network
www.cms.hhs.gov/MLNGenInfo
A planned and coordinated provider education program that offers timely, easy-to-understand materials such as national educational articles, brochures, fact sheets, web-based training courses, and videos.

Medicare Modernization Update
www.cms.hhs.gov/MMAUpdate

Medicare Provider-Supplier Enrollment
www.cms.hhs.gov/MedicareProviderSupEnroll

Medicare Provider-Supplier Enrollment Contacts
www.cms.hhs.gov/MedicareProviderSupEnroll/PSEC/list.asp#TopOfPage

National Correct Coding Initiatives Edits
www.cms.hhs.gov/NationalCorrectCodInitEd

National Plan & Provider Enumeration System
https://nppes.cms.hhs.gov

National Provider Identifier Standard
www.cms.hhs.gov/NationalProvIdentStand

Open Door Forums
www.cms.hhs.gov/OpenDoorForums

Partner Center
www.cms.hhs.gov/center/partner.asp

Pharmacists Partner Center
www.cms.hhs.gov/center/pharmacist.asp

Physician Fee Schedule
www.cms.hhs.gov/PhysicianFeeSched

Physicians Partner Center
www.cms.hhs.gov/center/physician.asp

Physicians Regulatory Issues Team
www.cms.hhs.gov/PRIT

Physician's Resource Partner Center
www.cms.hhs.gov/center/physician.asp

Practice Administration Information Resource Center
www.cms.hhs.gov/center/practice.asp

Practicing Physicians Advisory Council
www.cms.hhs.gov/FACA/03_ppac.asp

Prescription Drug Coverage
General Information
www.cms.hhs.gov/PrescriptionDrugCovGenIn

Private Fee-for-Service Plans
www.cms.hhs.gov/PrivateFeeforServicePlans

Public Affairs Center
www.cms.hhs.gov/center/press.asp

Quality Improvement Organizations
www.cms.hhs.gov/QualityImprovementOrgs/01_Overview.asp#TopOfPage

Quarterly Provider Updates
www.cms.hhs.gov/QuarterlyProviderUpdates

Regional Office Overview
www.cms.hhs.gov/RegionalOffices

Regulations & Guidance
www.cms.hhs.gov/home/regsguidance.asp

Resident Training Listserv
www.cms.hhs.gov/apps/mailinglists
Sign up to receive the latest Medicare Resident, Practicing Physician, and Other Health Care Professional Training Program information, including content updates to the *Medicare Physician Guide: A Resource for Residents, Practicing Physicians, and Other Health Care Professionals.*

State Health Insurance Programs
www.cms.hhs.gov/Partnerships/10_SHIPS.asp

Telehealth
www.cms.hhs.gov/Telehealth

Therapy Services
www.cms.hhs.gov/TherapyServices

Other Organization's Websites

Administration on Aging
www.aoa.gov

Agency for Healthcare Research and Quality
www.ahrq.gov

Commerce Clearing House
www.cch.com

Financial Institutions Examination Council
www.ffiec.gov/default.htm

General Services Administration
Excluded Parties List System
www.epls.gov

Health and Human Services Office of Inspector General
Compliance Guidance
www.oig.hhs.gov/fraud/complianceguidance.html

Health and Human Services Office of Inspector General
List of Excluded Individuals/Entities
www.oig.hhs.gov/fraud/exclusions/listofexcluded.html

Health Resources and Services Administration
www.hrsa.gov

National Technical Information Service
www.ntis.gov/help/subscriptions.asp

National Uniform Billing Committee
www.nubc.org/guide.html

Office of Minority Health
Cultural Competency Continuing Education Programs
http://thinkculturalhealth.org

U.S. Census Bureau
www.Census.gov

U.S. Department of Health and Human Services
www.hhs.gov

U.S. Government Printing Office
Code of Federal Regulations
www.gpoaccess.gov/cfr/index.html

U.S. Government Printing Office
U.S. Government Bookstore
http://bookstore.gpo.gov

REFERENCE D
REFERENCE MATERIALS

Commerce Clearing House Guide to Medicare and Medicaid
Commerce Clearing House, Inc.
www.cch.com
(800) 835-5224

ICD-9-CM Diagnosis Coding Book
American Medical Association
www.amapress.org
(800) 621-8335

Level I CPT Book
American Medical Association
(800) 621-8335
www.amapress.org

Level II HCPCS Book
American Medical Association
www.amapress.org
(800) 621-8335

Medicare Learning Network Publications (providers)
Centers for Medicare & Medicaid Services
www.cms.hhs.gov/MLNGenInfo

Medicare Publications (beneficiaries)
Centers for Medicare & Medicare Services
www.medicare.gov/publications/home.asp
(800) 633-4227

National Correct Coding Policy Manual in Comprehensive Code Sequence for Part B Medicare Carriers
NTIS Subscriptions Department
5285 Port Royal Road
Springfield, VA 22161
www.ntis.gov/help/subscriptions.asp
(800) 363-2068

CMS Library
C2-07-13
7500 Security Blvd.
Baltimore, Maryland 21244

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